Ontario Ministry of Health
Annual Report
1981–82

A CENTURY OF CARING

Ontario

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Bureau du
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of
Health

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The Honourable
John Black Aird, O.C.,Q.C., LL.D,B.A.
Lieutenant Governor of the Province of Ontario

May it please your honour:

It is my pleasure to present the fifty-seventh annual report of the Ministry of Health for the twelve-month period ending March 31, 1982, and the report of the Ontario Health Insurance Plan, as required under the Health Insurance Act.

Respectfully submitted,

Honourable Larry Grossman, Q.C.
Minister of Health

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Message from the Minister

It is in the nature of annual reports that the Minister in place when it is published is seen to take credit for the achievements of the year in question. I was appointed Minister of Health on February 13, 1982 — something less than two months before the end of the fiscal year covered by this report. While my deputy minister, Graham Scott, has a somewhat longer tenure, having joined the Ministry seven months earlier, we are both indebted to our predecessors Dennis Timbrell and Tom Campbell, whose leadership contributed to the past year's achievements.

At the time of my appointment, I looked on this new assignment both as a challenge and a unique opportunity.

I viewed it as a challenge because we are clearly facing a difficult situation: it is our desire to maintain, indeed improve, our excellent health care services; but we must deal with a system that has significant cost pressures in it, and we must do so with finite resources.

But I also see it as a unique opportunity for us to begin to plan for the medium and long term viability of our health care system.

This year marks the 100th anniversary of this Ministry. We have achieved much over the last century. In fact, our high standards of health care in this province say as much as any other measure about our morality and our respect for one another.

This report tells the story of a health care system that I believe is one of the best in the world. It also illustrates how we are moving to meet the changing needs of our society. Contained in this report are illustrations — living illustrations — of how the Ministry of Health is pursuing four complementary courses of action.

We are reducing the orthodox emphasis on acute hospital care by encouraging more effective approaches to treatment through de-institutionalization and community-based care.

We are increasing our focus on prevention and community health services — both of which offer the most significant opportunities for improvement in the overall level of health. Specific changes in this area involve a greater emphasis on public health and on increased financing of community-based Adult Mental Health Programs.

We are encouraging Ontario residents to take a greater personal responsibility for their health.

And we are stressing decentralization of planning by continuing to build our network of District Health Councils to advise and recommend on the health planning priorities of their respective communities.

But much more remains to be accomplished.

Today — perhaps as never before in our history — we are faced with an opportunity to shape the health care system of tomorrow. We have the opportunity to begin a process of fundamental reform — in fact to develop an overall health care strategy for this province.

During my first months as Minister of Health, I have listened very carefully to proposed alternatives from my staff, health care professionals, the Ontario Council of Health, and the District Health Councils right across the province. This advice has helped shape my impressions of both the problems and the solutions and can provide the basis upon which we can build a framework that will give us direction on where and how we are to proceed over the long term.

The challenges ahead will be difficult, but they can be met successfully. As we strive to meet these challenges, we will welcome innovative ideas from every sector of the health care system.

All of us — health care providers, strategic planners, hospital administrators, consumers, indeed everyone in the system — must assist in the process of developing new and innovative ways to deliver health care programs without ever sacrificing the quality of care.

I am convinced that, together, we can forge new paths, open new avenues, and devise new approaches to ensure that we maintain and continue to improve the quality of our health care delivery system.

Honourable Larry Grossman, Q.C.
Minister

Message from the Deputy Minister

The Ministry of Health of Ontario is a descendant of the Provincial Board of Health which was formed on March 10, 1882. In those days of pioneers and tiny communities in a massive, intimidating province, the annual reports that told the stories of each year of health care in Ontario were simpler, rather folksy documents. In those days, meetings of the Board of Health dealt with the novelties of indoor plumbing and, occasionally, epidemics of smallpox and tuberculosis. In those early days, clearly, the Board of Health was very much a creature of the community rather than the keeper and the overseer of a universal, modern 'system.'

Through the years and decades that passed, both the Board and its annual report yielded to progress, and the community spirit of the province's health workers was replaced by sophistication and the accurate but much drier language of statistics and bureaucracy.

Today's health care system, and the Ministry which has descended from that first Provincial Board of Health, are more advanced, more technologically minded and more professionally fit than anyone could have imagined a score of years ago, much less in 1882.

The system was forged in pioneering days when its small coterie of professionals fought against general ignorance of the basics of public health. It has gone through a growth period of concentration on large, often remote, institutions. These did accelerate the introduction of effective, costly technology into the system, but made the pejorative word "warehousing" all too apt in descriptions critical of health care.

Now, in many ways, the system is returning to the community. Local hospitals are bringing all aspects of health care into neighborhoods. Home care for the chronically ill, the disabled, and the convalescent, is being stressed, along with the need for proper nutrition and fitness. Health care has "come home".

In keeping with this major shift in health care for Ontario, the Ministry is returning to the narrative style of earlier annual reports. The emphasis of this report is on specific activities of the Ministry over the fiscal year, and how those actions fit together in the mosaic which is today's health care system. We want to tell the story of our Ministry as well as publish its vital statistics.

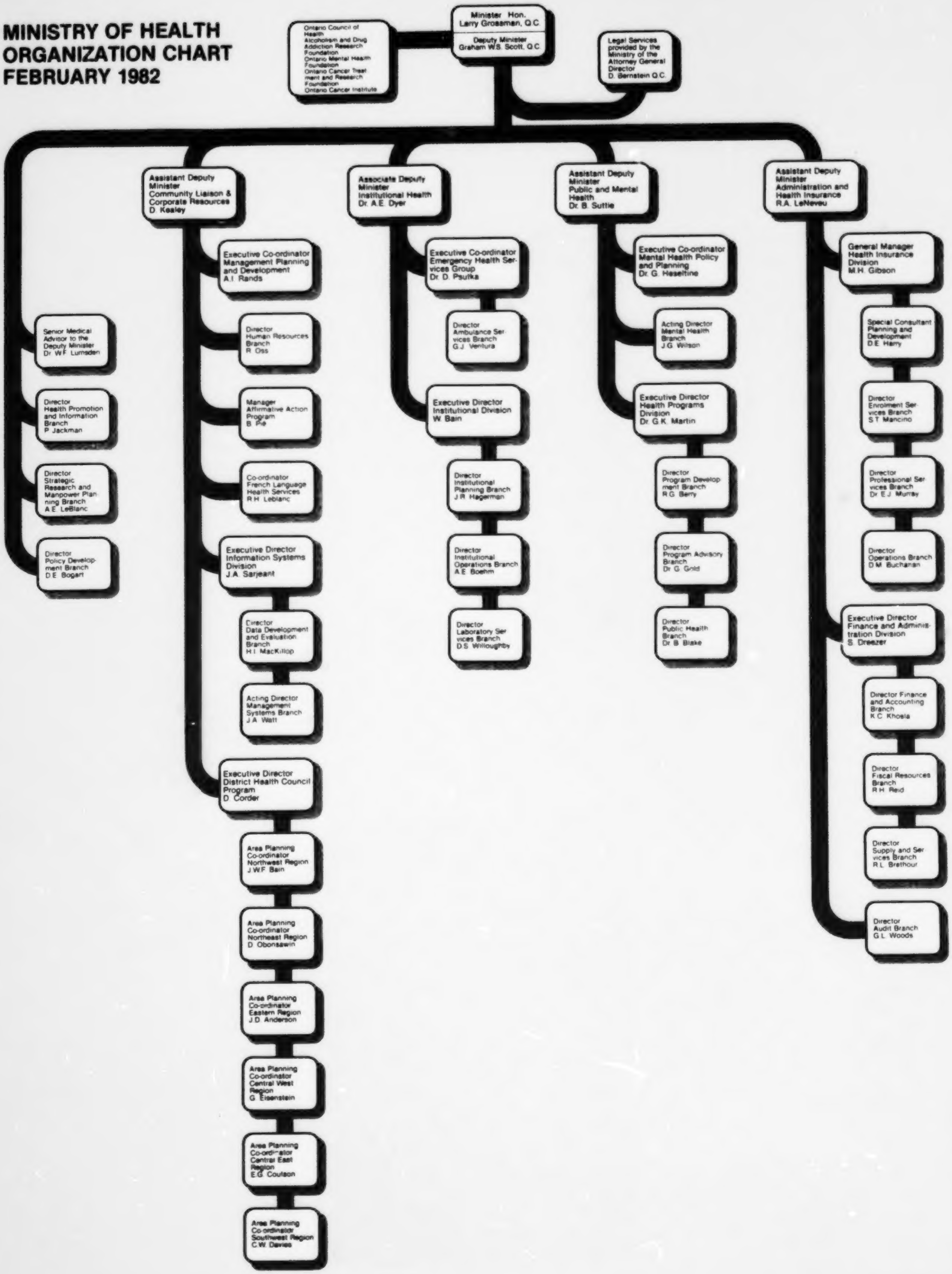
The final section of the report comprises a history of the health care system in Ontario from 1882 to 1982, and a brief description of the province before organized health care came into being. This history is drawn largely from the 99 annual reports prepared before this one.

The reader will find that the history of our health care system is filled with drama, excitement, trials and tragedy as well as triumph.

With this annual report, we close one era of health care in Ontario and open another. We hope and trust that this new era, this new chapter, will be as rewarding for the people of Ontario as were the last 100 years in what was truly a century of caring.

Graham W.S. Scott, Q.C.
Deputy Minister

MINISTRY OF HEALTH ORGANIZATION CHART FEBRUARY 1982


Minister Hon. Larry Grossman, Q.C.
Deputy Minister Graham W.S. Scott, Q.C.
Ontario Council of Health Alcoholism and Drug Addiction Research Foundation Ontario Mental Health Foundation Ontario Cancer Treatment and Research Foundation Ontario Cancer Institute
Legal Services provided by the Ministry of the Attorney General Director D. Bernstein Q.C.
Senior Medical Advisor to the Deputy Minister Dr W.F. Lumsden
Director Health Promotion and Information Branch P Jackman
Director Strategic Research and Manpower Planning Branch A.E. LeBlanc
Director Policy Development Branch D.E. Bogart
Assistant Deputy Minister Community Liaison & Corporate Resources D. Kealey
Executive Co-ordinator Management Planning and Development A.I. Rands
Director Human Resources Branch R. Oss
Manager Affirmative Action Program B. Pie
Co-ordinator French Language Health Services R.H. Leblanc
Executive Director Information Systems Division J.A. Sarjeant
Director Data Development and Evaluation Branch H.I. MacKillop
Acting Director Management Systems Branch J.A. Watt
Executive Director District Health Council Program D. Corder
Area Planning Co-ordinator Northwest Region J.W.F. Bain
Area Planning Co-ordinator Northeast Region D. Obonsawin
Area Planning Co-ordinator Eastern Region J.D. Anderson
Area Planning Co-ordinator Central West Region G. Eisenstein
Area Planning Co-ordinator Central East Region E.G. Coulson
Area Planning Co-ordinator Southwest Region C.W. Davies
Associate Deputy Minister Institutional Health Dr. A.E. Dyer
Executive Co-ordinator Emergency Health Services Group Dr. D. Psutka
Director Ambulance Services Branch G.J. Ventura
Executive Director Institutional Division W. Bain
Director Institutional Planning Branch J.R. Hagerman
Director Institutional Operations Branch A.E. Boehm
Director Laboratory Services Branch D.S. Willoughby
Assistant Deputy Minister Public and Mental Health Dr. B. Suttie
Executive Co-ordinator Mental Health Policy and Planning Dr. G. Heseltine
Acting Director Mental Health Branch J.G. Wilson
Executive Director Health Programs Division Dr. G.K. Martin
Director Program Development Branch R.G. Berry
Director Program Advisory Branch Dr. G. Gold
Director Public Health Branch Dr. B. Blake
Assistant Deputy Minister Administration and Health Insurance R.A. LeNeveu
General Manager Health Insurance Division M.H. Gibson
Special Consultant Planning and Development D.E. Harry
Director Enrolment Services Branch S.T. Mancino
Director Professional Services Branch Dr. E.J. Murray
Director Operations Branch D.M. Buchanan
Executive Director Finance and Administration Division S. Dreezer
Director Finance and Accounting Branch K.C. Khosla
Director Fiscal Resources Branch R.H. Reid
Director Supply and Services Branch R.L. Brethour
Director Audit Branch G.L. Woods

Restructuring Places Focus on Better Community Care

Many times during their 100-year history, the Ministry of Health and its forerunners have seen organizations and re-organizations of their various components — changes carried out so that the health care system could be reshaped to suit changes in society's needs.

One of the more sweeping examples was the removal of the whole health care system from the umbrella of labour departments and ministries. Another was the removal from the health ministry of its responsibility for air quality and purity of municipal water supplies, functions transferred to the Ministry of the Environment.

In this fiscal year, there was a major re-organization within the Ministry, preparing it to sharpen its growing community care and corporate improvement focus.

One aspect of this re-organization, for instance, was the coming together into one group of the province's 10 psychiatric hospitals, the adult community mental health programs, and policy development affecting psychiatric units in public general hospitals. Another aspect was the establishment of an Emergency Health Services Group to be responsible for planning and development for all emergency services.

Because of the re-organization, the Ministry's various functions are now divided into five separate areas, four of which have their own associate or assistant deputy ministers. The fifth group reports to the Deputy Minister.

Institutional Health Services:

This group is responsible for directing and monitoring the programs in health care institutions including public and private hospitals, nursing homes, and related facilities.

The group's mandate includes approving plans and funding for construction of new public hospitals, and renovations to existing facilities. It provides operating grants and advice on the administration of these institutions. The group also licenses and inspects nursing homes, x-ray facilities and private laboratories. It administers direct laboratory services and oversees emergency health services including air and land ambulances.

Public and Mental Health:

This group is responsible for both the psychiatric institutions and community-based mental health programs; the Ministry can thus take a consolidated approach to the development of continuous care for the mentally ill.

As well, this group devises programs and policies to ensure effective delivery of public health care in the province.

The public and mental health group also acts as a liaison group for the health disciplines and implements programs for preventing disease and disability. Programs to encourage people to take more responsibility for, and interest in, their own well-being are a Ministry priority, as are a number of programs aimed at prevention of disease through such methods as immunization, family and nutritional counselling and sanitation inspections.

Administration and Health Insurance:

This group is responsible for the Ontario Health Insurance Plan, known to everyone in the province as OHIP.

Apart from that major responsibility, this group provides a range of administrative services to other divisions of the Ministry including financial management and accounting, internal and external audits of health agencies, co-ordination of SI (metric) conversion and the supply of goods and services to the Ministry. The group also provides services to various statutory appeal boards through the Health Boards Secretariat.

Community Liaison and Corporate Resources:

This is a new group in the Ministry's organization: it manages the District Health Council program which is developing local participation in decision-making in the health care system. In keeping with its decentralization plans, the Ministry is depending more and more on advice from local communities on how to tailor the health care system to their own needs. The province's 25 DHC's are composed of local representatives who can assess and co-ordinate local needs and resources.

In its corporate resources role, this group develops and evaluates information on all aspects of health in Ontario, and develops management planning systems and human resource planning and services. The Ministry's French Language Services and Affirmative Action Program are part of the group.

Several specialized services report directly to the Deputy Minister. These include:

Health Promotion and Information Branch, which is responsible for all public and media communications and requests for information, as well as for advertising and promotion of the preventive aspects of health care.

Strategic Research and Manpower Planning Branch, which promotes and provides support for corporate planning for the long term. This branch manages the health research grants and bursaries program, directs the clinical education program, and provides liaison between the Ministry and the Ontario Council of Health.

Policy Development Branch, which analyzes and recommends strategy and policy changes for emerging health care issues and provides advice on policy issues to other parts of the Ministry.

Hospitals Receive $120 Million for New Buildings, Additions

Out of its total budget (almost $6 billion) for the year, the Ontario Ministry of Health spent by far the largest amount on the operation, expansion and construction of the province's 230 general hospitals. The capital budget for 1981–82 was $120 million, of which $33 million came from provincial lotteries.

The largest single outlay during the year for capital works was $22,134,000, the Ministry's share of the building of a new six-storey wing at Hotel Dieu Hospital in Kingston.

The hospital wing is the third phase of a redevelopment project for the hospital. It will house emergency and ambulatory care areas, the operating suite, critical care units, the medical imaging department, new in-patient pediatrics unit, a children's centre and an out-patient clinic.

Eventually, the addition to the hospital will help to save health care money in the area, because it is making it possible to rationalize some services in the city. For instance, it will allow an amalgamation of the pediatric services of Hotel Dieu and Kingston General Hospital, and of the psychiatric units of the two hospitals.

Capital costs can be high in smaller centres too. For example, on January 5, 1981, the Ministry announced approval of $5,755,860 for the enlargement of two wings of St. Joseph's General Hospital in Elliot Lake. This enlargement allows the hospital to add new emergency, out-patient and laboratory departments, to renovate and expand its radiology department, and to add a special care unit.

Of that total of almost $6 million, the Ministry is paying $3,830,574, with the hospital and the community of Elliot Lake raising the remaining funds.

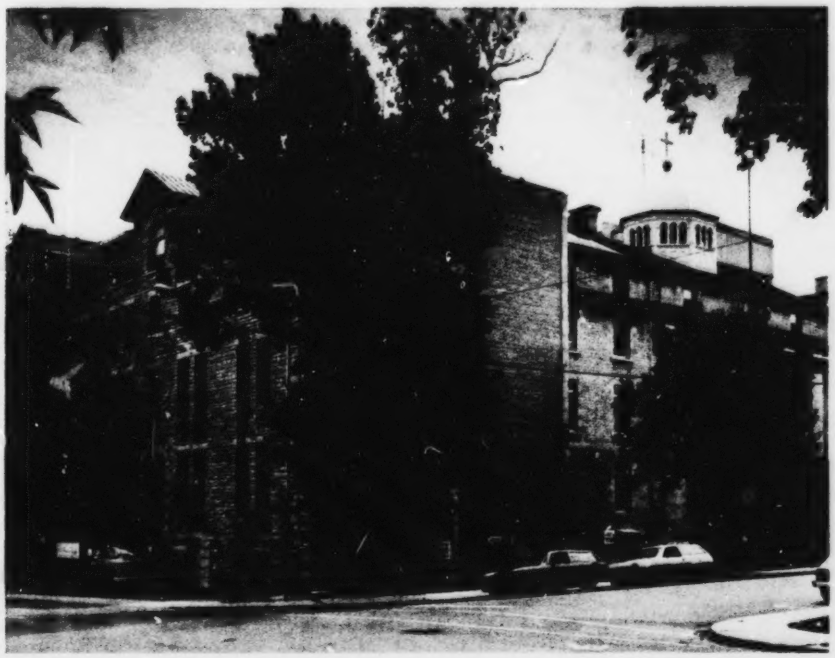
With capital costs such as these, the Ministry and the hospitals must ensure that funds are spent on the kind of care most needed by communities. For several years the Ministry has been encouraging different approaches to the treatment and rehabilitation of acute care patients. For instance, it has been encouraging day surgery for minor operations which can be done on an out-patient basis.

During the fiscal year, the Ministry gave approval to Belleville General Hospital to relocate and expand its day surgery and related facilities. The Ministry will fund two-thirds of the capital cost. This kind of project is becoming more common as hospitals upgrade or add day surgery facilities, so that patients may go home after minor surgery, rather than stay overnight in acute care beds.

Other out-patient alternatives to in-patient acute care in hospital settings include pre-admission diagnostic tests (such as laboratory tests), and workups and treatments such as dialysis and psychiatric care, where patients can be treated as out-patients.

Surveys show repeatedly that between 10 and 20 per cent of patients in acute care beds could have been cared for in long-term care facilities. As a result, more emphasis has been placed, in recent years, on lower cost alternatives such as home care and chronic home care programs, nursing homes and chronic care facilities.

The demands arising from an aging population are being built into the Ministry's forward planning. Greater emphasis is being directed towards the provision of appropriate long-term care facilities. Additional home care and nursing home beds are being brought into service, and the chronic home care program is being expanded.



Hotel Dieu Hospital, Kingston. A $24 million six-storey wing was the largest capital project at an Ontario hospital during the year.

A significant move in this direction began in July, 1981, when approval was given to Queensway General Hospital in Etobicoke to negotiate with the private sector to plan for a new 120 bed chronic care facility to be built on the hospital site. The new unit is expected to open in 1984.

Even though funding is provided to hospitals by the Ministry both for capital costs and operating expenses, the general hospitals are operated, on a principle of local autonomy, by voluntary boards.

The Ministry approves capital building projects and major new items of equipment.

For community hospitals in Southern Ontario, the Ministry pays two-thirds of capital construction costs, while the hospital is responsible for the rest. In the north, the Ministry pays five-sixths of the costs of community hospitals in those areas where the population is less than 12,000.

Teaching hospitals in the province received 100 per cent funding for capital projects to upgrade out-dated facilities, under the Ontario Health Resources Development Plan, which came into effect in 1973.

Because of growing costs, both in operating and capital costs, hospitals take about half the total health budget.

Orpington Hospital as it was in World War II. Orpington Hospital was operated by the Canadian Army during World War I. Many of its sections are named after Canadian provinces.

World War I Hospital Remembered

The Ministry of Health made one grant this year to a hospital several thousand miles away in distance but close to the hearts of many Canadians.

The Ministry awarded $6,000 to the Orpington Hospital in England for a public address system.

Orpington was operated by the Canadian Army for wounded servicemen in the First World War. This year, the famous hospital is completing a building program including replacement of the original "Ontario Hall" with a new social-recreational facility, which will bear the same name.

Now 24 CAT Scanners Placed Across Ontario

Just before the year end, on March 24, 1981, the Kitchener-Waterloo Hospital received some good news: it was given Ministry approval to obtain Ontario's 24th CAT scanner, the latest development in x-ray technology.

CAT stands for computerized axial tomography. The outstanding advantage of a CAT scanner is that it examines cross-sections of the body, including soft tissue, in minute detail, through the use of a narrow x-ray beam and computer printouts.

With a CAT scanner, an accurate diagnosis of many ailments can be made with a minimum of risk and discomfort to patients.

The 24 machines in the province have been approved by the Ministry and listed in the Regulations of the Public Hospitals Act. The Ministry provides $150,000 to each hospital with a CAT scanner for its annual operating costs.

Other hospitals that received approval for CAT scanners were Scarborough General, Wellesley, Mount Sinai, and Children's Hospital of Eastern Ontario.

New Hospital Plan: BOND

Hospital administrators, during this fiscal year, were offered a new opportunity to make use of some innovative practices used by businesses to add to patient care at their institutions without relying totally on Ministry funding.

Although the Ministry has provided, and will continue to provide, the bulk of hospital funding, hospital administrators will be able to take advantage of a plan announced on December 2, 1981, and dubbed BOND, (the Business-Oriented New Development Plan).

BOND is fundamentally a program of incentives. Its main ingredient is that hospitals will retain 100 per cent of any savings in costs, plus 100 per cent of any revenue generated by the hospital.

Before the start of the BOND plan (on April 1, 1982), hospitals were required to turn back to the Ministry any underspending of their Ministry-approved budget. Under BOND, administrators will keep those funds, providing hospitals with a pool of funds they can call their own and which they can spend on patient care improvements or new equipment.

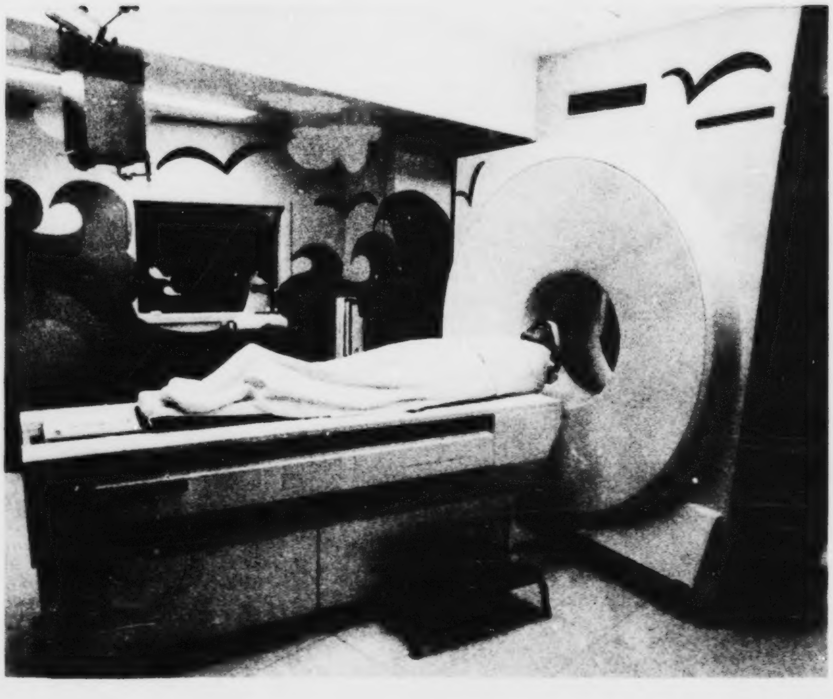
BOND will give hospital administrators extra incentive for containing their spending through better business management practice, and for increasing some of their revenues. BOND will also give our province's 230 general hospitals more autonomy, and increase local control. For example, the hospitals will decide their own rates for preferred accommodation. They may also set their own rates for charges to uninsured patients and to all agencies other than the Ontario Ministry of Health and health plans in other provinces.

BOND also permits the hospitals to apply to the Ministry for approval to increase semi-private and private accommodation.

The plan gives hospital managers the incentive to generate additional revenue through services such as parking lots or cafeterias — revenue which can then go to improve patient care.

At the same time, small hospitals continue to be given protection in terms of bed numbers. The Ministry will continue to see that available resources from the government are shared as fairly as possible.

BOND does not affect our national insurance program. Each hospital bed in the province continues to be an insured bed, and every patient is entitled to the type of hospital accommodation and treatment that he or she requires.



A patient at Toronto's Hospital for Sick Children undergoes a CAT scan diagnosis. There were 24 CAT scanners at Ontario hospitals during the fiscal year.

Solar Laundry

The largest solar energy project in Canada in this fiscal year was not only undertaken right here in Ontario, it was part of our hospital system.

The project, financed jointly by the federal and provincial governments and Mohawk Hospital Services Inc., of Hamilton, is a $1.3 million solar system to preheat the 585,000 L of water used by Mohawk every day. The company is a non-profit laundry service financed by Hamilton area hospitals.

The system is intended to save an estimated 25,000 barrels of oil during its expected 20-year life span. The Ministry of Energy will monitor the solar energy produced by the system as a pilot program.

The Ministry of Health, with the Ministry of Energy, provided advisory services for the design and construction of the project.

Hospital Supervisor

New legislation passed this year permits the appointment of a hospital supervisor when an institution is having problems that cannot be solved in other ways.

The legislation — an amendment to The Public Hospitals Act — allows a supervisor to be appointed for a hospital, by the Lieutenant Governor in Council, where a study of the quality of the hospital's management or patient care indicates that the appointment would be in the best interest of the public. It is similar in intent to legislation already in existence in some other provinces.

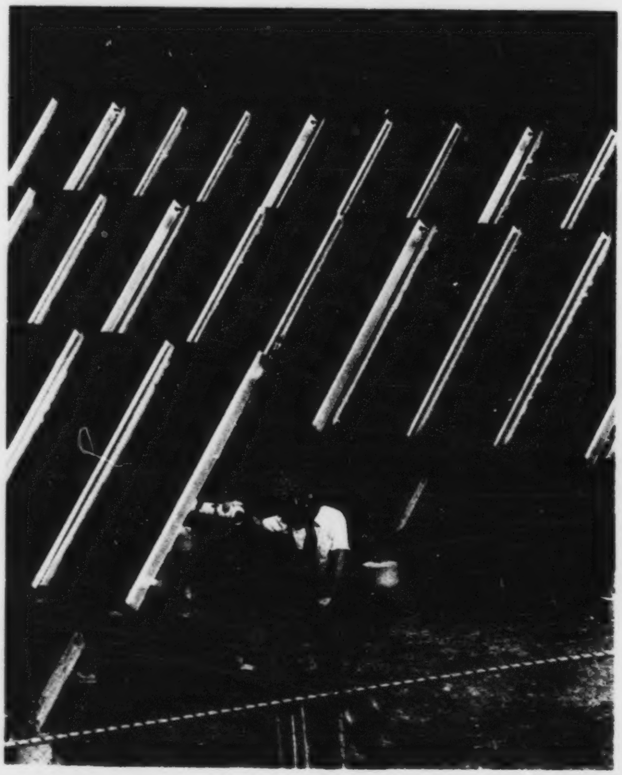
On July 30, 1981, the Ministry announced the appointment of Gerald P. Turner as hospital supervisor for Toronto East General and Orthopaedic Hospital. Mr. Turner is executive director of Mount Sinai Hospital, Toronto.

The East General board of directors and the administrator work with Mr. Turner's advice and guidance to improve aspects of hospital management and patient care.

More Nursing Home Beds

The Ministry continued to approve additional nursing home beds across the province during the fiscal year. For example: 28 more beds for the Region of Peel, 60 for Durham, 56 in the Thames Valley, 300 for Metro Toronto, and 100 more for Metro Windsor. The beds were added through the building of new homes, additions to existing homes, and the upgrading of nursing homes in various centres. The addition of beds was evidence of the Ministry's desire to increase the provision of long-term care as an alternative to acute hospital care. More beds are also needed to meet the challenge of a rapidly aging population.

Through the Institutional Operations Branch, the Ministry distributes operating funds to nursing homes. Although the homes themselves are largely privately owned and operated, a small number are operated by hospitals or municipalities. The branch also directs the nursing home inspection service, which monitors the operations of nursing homes. This service ensures that residents receive a high standard of nursing and personal care in a safe and attractive environment.



A proud project manager, John Parker, poses with the solar collector panels at Mohawk Hospital Services Inc. in Hamilton. Mohawk's solar laundry is Canada's largest solar energy project.

The solar-operated Mohawk Hospital Services Inc. laundry in Hamilton provides non-profit service to Hamilton's hospitals. 585,000 L of water are heated each day for these washers and dryers.

Regular inspections and complaint investigations are carried out by nursing, fire safety, and environmental health inspectors.

The service also reviews plans for new nursing homes and for additions or renovations to existing homes.

Approval of additional nursing home beds in various areas is based on advice from the District Health Council, wherever one has been established.

Private Hospitals

During the year there were 19 private hospitals, which provided both acute and chronic care services. The Smith Clinic Hospital was closed as it amalgamated with Hawkesbury and District Hospital. The number of beds on March 31, 1982, was 847.

Laboratory Services

The Laboratory Services Branch provides diagnostic and reference laboratory services through the Central Public Health Laboratory in Toronto, 12 Regional Public Health Laboratories, and one subsidized hospital laboratory. More than 3.3 million specimens were analyzed in 1981–82.

Interior of an early Ontario Board of Health Testing Laboratory in Lindsay.

There was a considerable increase in the number of reference services provided, particularly in the field of virology:

- The Neonatal Screening Program processed approximately 130,000 specimens from newborns and identified 32 cases of primary hypothyroidism and 12 cases of phenylalanine metabolism deficiency.
- The Arbovirus Surveillance Program was continued in southwestern Ontario using flocks of "sentinel chickens".
- The Central Laboratory was asked to assist in the analysis of air samples from homes with urea formaldehyde foam insulation.
- The Serology and Mycology laboratories identified an increase in systemic fungal infections in previously uninfected areas of the province.

Staff members from all laboratories provided training for health care professionals from hospitals, universities and community colleges; several staff teach at local universities and others present special courses in conjunction with teaching institutions and professional societies. Each laboratory worked with local health units to identify and provide appropriate health services for their communities. The Laboratory Inspection Service carried out routine and investigative inspections of hospital and private laboratories. In collaboration with the Laboratory Proficiency Testing Program of the Ontario Medical Association, the Inspection Service was able to take corrective action to ensure a high level of proficiency in laboratories throughout the province.

Imported Diseases Prompt Laboratory for Maximum Isolation

Increased travel between Canada and the third world countries has increased the possibility that travellers entering Canada will be incubating "exotic" communicable diseases such as the African hemorrhagic fevers Lassa and Ebola, not normally found in northern countries. Such travellers present a risk to other people as these diseases are highly contagious and frequently fatal.

The diagnosis of these viral diseases is difficult in the early stages of infection, since initial symptoms are the same as those for more common illnesses such as influenza and malaria. Until diagnosis can be made, the patient must be isolated, and all laboratory tests must be performed in a high security laboratory which will protect the laboratory personnel and the environment from infection. At the present time there are no such facilities in Canada and, in the past, specimens had to be flown to the Center for Disease Control in Atlanta, Georgia, for virus isolation.

A maximum containment laboratory for the identification of the exotic diseases has been planned for Central Laboratory. The special features of the laboratory include: the use of sealed cabinets with gloveports for the manipulation of specimens; a separate air supply and exhaust system with high efficiency filters to prevent escape of infectious particles to the laboratory or to the outside atmosphere; sealed walls, floor, and ceiling to prevent leakage to other areas of the building; and separate liquid waste discharge with a decontaminating cycle prior to final discharge.

The laboratory is in the final stages of planning.

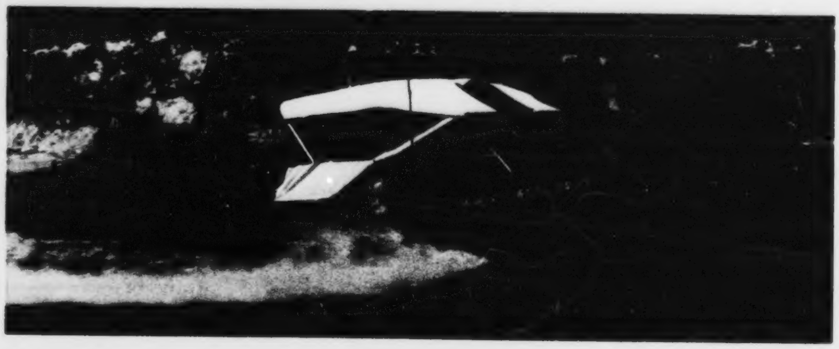
Emergency Group Oversees all Services

New strength and focus was added to the province's emergency health services this year as the Ministry continued to refine a process begun in the last fiscal year.

It began in January, 1981, with the establishment of the Emergency Health Services Group as the focus for planning, development, co-ordination, and management of all emergency health services in the province.

In August of this fiscal year, Dr. Dennis Psutka was appointed Executive Co-ordinator of the new group. He has an extensive background in emergency care training and was Chief of the Department of Emergency Care for Hamilton Civic Hospital at the time of his appointment.

One of the group's priorities is disaster planning. No sooner was the group formed last year than it was faced with providing operational support for on-site co-ordination of health resources at the Medonte train derailment incident in February, 1981. The derailment posed the danger of a major chemical spill, but that was avoided.



The Ministry's emergency support units range from this small, fast boat to busses capable of use in mass evacuations and multi-victim accidents. The boat is used by the James Bay Ambulance Service in Moosenee to transfer patients from James Bay General Hospital to Moose Factory Hospital.

A train derailment involving hazardous chemicals provided an acid test for the Ministry's new Emergency Health Services Group. The Ministry's work at this accident at Medonte was completely successful.

In a graphic illustration of the total integration of emergency services, a patient is transferred from a land ambulance to a fixed-wing aircraft of the Ministry's air ambulance fleet.

The mandate of the new group is to build on the extensive emergency health system already in place and to ensure a sound integration of all of the system's essential components. Those components include pre-hospital services such as the ambulance service, hospital, and inter-hospital phases, and the development of advanced life support or 'paramedic' capability.

Since its inception, the group has enhanced the Ministry's ability to assist local health agencies in the planning and operational stages of response to such emergencies.

This fiscal year, the group conducted four simulated emergency exercises as part of its disaster training program.

The group also acquired and equipped a large, five-ton emergency support unit which can be used to carry heavy loads of emergency supplies.

For such emergencies as chemical spills, the group obtained 100 breathing apparatus and acid protection outfits.

The North Gets Air Ambulance Fleet

One very special improvement in the delivery of health services to the people of Northern Ontario this year was the creation of a full-time air ambulance fleet equipped and operated by the Ministry of Health.

In the past, the northern areas of the province relied on chartered aircraft to bring sick or injured citizens to hospitals. The Ministry did have one aircraft for its exclusive use, a helicopter named 'Bandage 1', capable of caring for and transporting seriously ill or injured patients to a tertiary care hospital. This helicopter is based just outside Toronto.

Now, in keeping with the Ministry's policy of providing as much self-sufficiency in health care as possible in Northern Ontario, two helicopters and two fixed-wing aircraft have been dedicated to health service and are based in northern centres.

This new air ambulance fleet went into action on July 6, 1981. Its estimated cost of $8 million a year is shared by the Ministry of Health and the Ministry of Northern Affairs.

A Bell 212 helicopter, 'Bandage 2', is based in Sudbury to serve Northeastern Ontario.

A Sikorsky S-76 helicopter, 'Bandage 3', is in Thunder Bay and ready to go anywhere in Northwestern Ontario.

A Cessna Citation I, 'Bandage 4', a fixed-wing jet aircraft, is based in Timmins. It will be on hand for patients in the northeast while a sister craft, a Beechcraft King Air 200 Turbo Jet airplane, 'Bandage 5', is based at Sioux Lookout for service in Northeastern Ontario.

Bandage 5, one of three helicopters and two fixed-wing aircraft which make up the Ministry's air ambulance fleet. Four of these craft are based in Northern Ontario.

The aircraft are leased from Ontario firms and have been equipped by the Ministry to handle most medical emergencies. They are staffed by Emergency Medical Care Attendants (EMCA), personnel who have completed special air escort training. The training of these attendants includes air ambulance evacuation techniques, survival skills in the north, and simulated rescue operations under northern flying conditions.

Funding for this air ambulance fleet was included in $15 million in extra money planned for major improvements in Northern Ontario health services by the Ministry of Health and the Ministry of Northern Affairs. The northern air ambulance service is being evaluated at the end of one year of service. That evaluation will lead to recommendations for improvements which can be made and includes an analysis of the types of aircraft that would be most suitable for use on a permanent basis. Planning for the air ambulance service is carried out by the new Emergency Health Services Group formed in January of the 1980–81 fiscal year.

Heliports

To fully utilize the capabilities of helicopter ambulances, appropriate landing facilities are essential. Ideally, these helipads would be on hospital property, and situated as near as possible to the emergency department. The Ministry is providing funding assistance to a number of hospitals to facilitate the construction of helipads, licensed by Transport Canada for 24-hour operation.

Bandage 1, an air ambulance based at Buttonville Airport north of Toronto, sets down on its helipad. Bandage 1 was the first air ambulance to see service in Ontario.

Land Ambulances Upgrade Communications, Training

The backbone of Ontario's ambulance service is, of course, its more than 550 ambulances stationed throughout the province. This ambulance fleet is managed in a variety of ways to suit the various areas it serves: 77 ambulance services are privately operated, 71 are managed by hospitals, 11 are operated by municipalities, 26 by volunteers, and 10 are operated directly by the Ministry. In addition, the Ministry operates six central ambulance dispatch services.

The Ministry provides continued maintenance and upgrading of the basic ambulance service system. It reviews the need to modify ambulance vehicles and devises strategies to standardize ambulance supplies and equipment throughout the province.

The Ministry also maintains and improves the telecommunications networks that are so important to the emergency health services system. The Northern Ontario Ambulance Radio System-East provides total communications capability for ambulances from Sault Ste. Marie north to White River, east to Thessalon, and north to Timmins.

In the area of ambulance manpower development, the Ministry has continued its efforts to upgrade the qualifications of employees in the ambulance system. The Ministry now has more than 60 per cent of the full-time driver-attendants certified as Emergency Medical Care Assistants. Upgrading of the volunteer and part-time driver-attendants is proceeding with the introduction of "distance learning programs" (correspondence courses), to carry the basic and community college programs to the trainees.

Monica Lowenberger of the St. Catharines District Ambulance Service was awarded the 1981 McNally Award for bravery during a rescue. She accompanied two police officers onto melting ice in the Welland Canal to rescue a girl. Here she administers care to a patient in a land ambulance.

The Ministry also provides a variety of training programs in patient care, driving skills, light rescue, and other skills essential to the driver-attendants, dispatchers, and management personnel.

$15 Million Perinatal Program Begins

A major drive to expand Ontario's perinatal facilities had its beginnings this year. The Ministry plans to spend $15 million over five years to establish regional perinatal programs across the province.

The new programs are being set up to prevent problems through the education of women of child-bearing age, and appropriate treatment of high-risk mothers and newborns.

Existing treatment facilities at five major teaching hospitals in Toronto, London, Ottawa, Kingston and Hamilton will be expanded or upgraded through the program. As well, new units will be established, including at least two in the north.

The five-year program will also place an emphasis on training health professionals to identify high-risk situations early in pregnancy.

The existing perinatal services have already helped to reduce the perinatal death rate to almost half of what it was at the end of the 1960's. That rate should continue to fall as new facilities are added.

Prosthetic devices such as an artificial leg or hand, wheelchairs, orthotic devices and hearing aids and other equipment used by children 18 or under, will be partially funded by the Ministry of Health under a program announced this year. The Ministry will pay 75 per cent of costs for such equipment. This photograph was taken at the Ontario Crippled Children's Centre in Toronto.

Children to Have Support for Assistive Devices

Under a new program the government will pay 75 per cent of the cost of selected assistive devices to help 15,000 young people across Ontario.

Those covered will be 18 or under and need devices such as wheelchairs, artificial limbs, braces, hearing aids and genito-urinary and ostomy drainage supplies. The program's estimated annual cost is $13 million.

Announced in response to the International Year of Disabled Persons, the program was to begin July 1, 1982.

On March 5, 1982, the Ministry announced the formation of a 17-member committee which is to help establish guidelines for the program. The group will also help the Minister to evaluate the program over its first two years to see that it does meet the needs of the youngsters and to assess the implications of expanding such benefits.

The public can obtain details of the program by writing:

Assistive Devices Program
Ontario Ministry of Health
7 Overlea Boulevard
Toronto, Ontario
M4H 1A8

or calling: 1-800-268-6021 (toll free)
or 963-1959 (Toronto)
or 1-800-268-6023 for TTD, or "Visual Ear" — a device that allows telephone communication with people who have a severe hearing impairment.

A mother tends her infant, who is in an incubator at the perinatal unit in Toronto's Hospital for Sick Children. The Ministry is expanding perinatal services throughout the province.

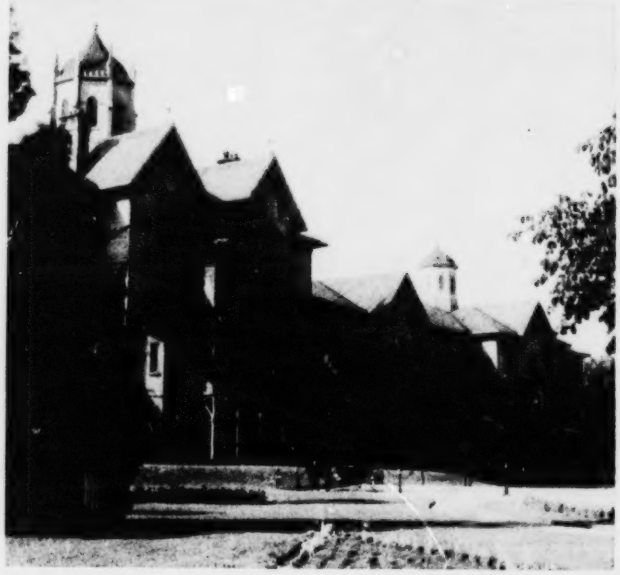
New Programs Expand Community Mental Health

The Adult Community Mental Health Program is the cornerstone for the Ministry's continuing efforts to expand community-based care for the mentally ill. Over the past three years the number of programs has risen to 125, treating 15,000 people a year.

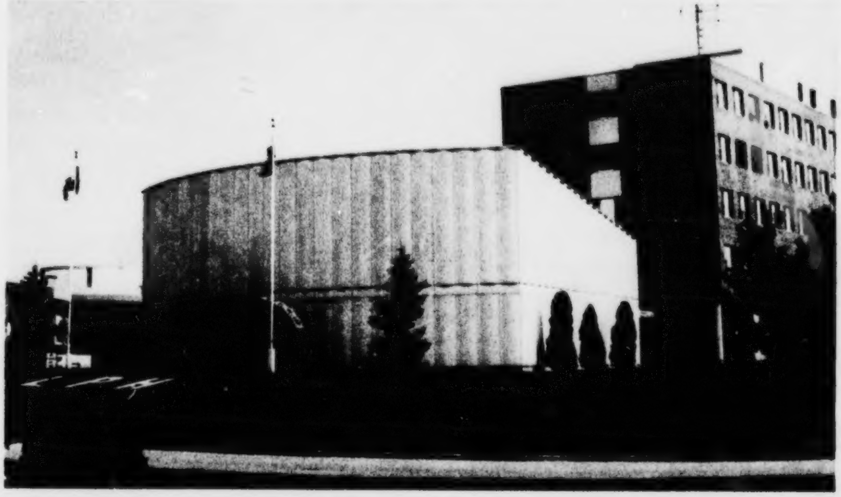
Many general hospital psychiatric units serve as headquarters for various community-based mental health services. For instance, one of the grants announced in November, 1981, was for $50,013 to Sydenham District Hospital for an outreach program providing psychiatric assessment and referral services to Wallaceburg and area residents. That program has back-up support from the mental health clinic of the Public General Hospital in Chatham.

Other new programs granted funds this year included: a new halfway house for discharged psychiatric hospital patients in Halton Region; a new community program geared especially to the long-term needs of chronically disabled former psychiatric patients in Ottawa; a variety of new services for emotionally disturbed adults in Hamilton; and a new mental health clinic in Chapleau.

A step toward bringing a full range of health services to Northern Ontario was taken in March, 1982, with the establishment of a seven-member steering committee to develop a mental health program to serve children and adults 'north



Photographed around 1928, this was the main building of London Psychiatric Hospital.



London Psychiatric Hospital as it is today

Patients at work in the fields around London Psychiatric Hospital in the early 1900's. Richard Bucke, Superintendent of the hospital from 1877 to 1902, believed in the therapeutic value of work for the patients.

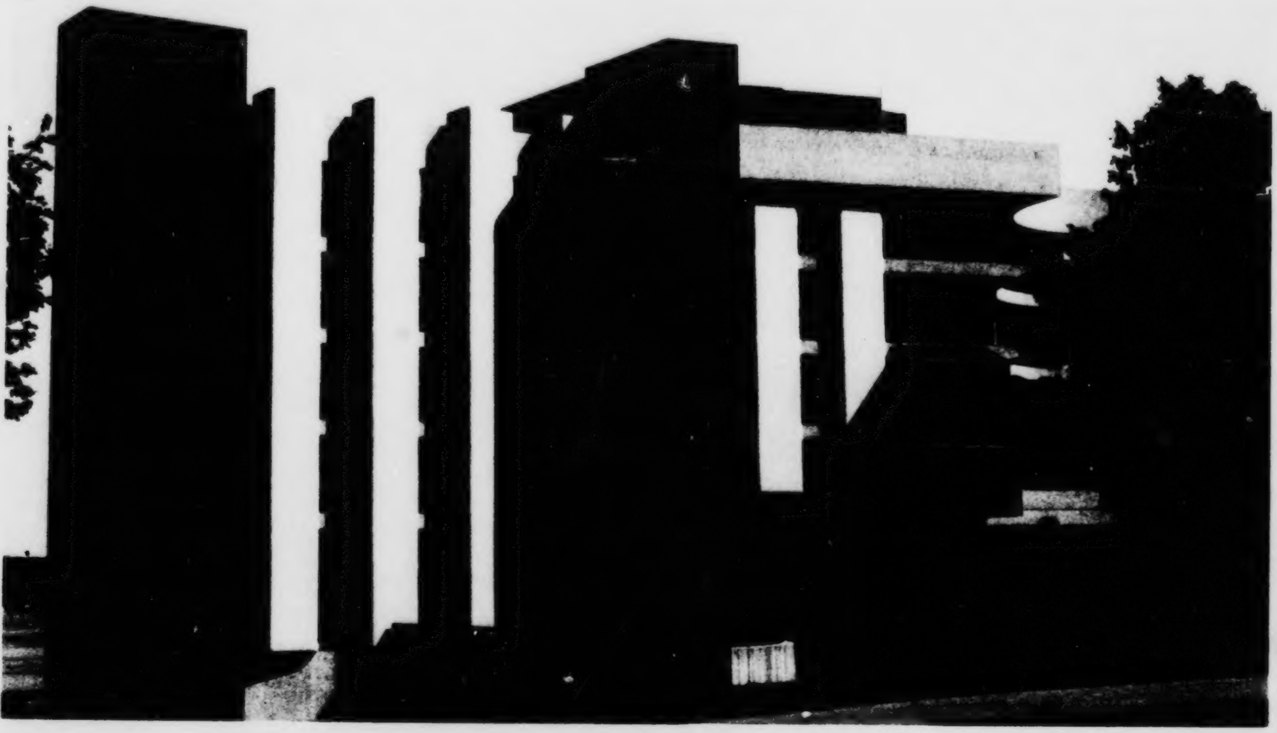
of Superior'. The area includes the communities of Geraldton, Longlac, Manitouwadge, Marathon, Terrace Bay, Schreiber and Nipigon.

The committee was to put together the framework and to recommend outstanding individuals to serve on a board to manage the program. The Ministry of Health and the Ministry of Community and Social Services are sharing the costs of the program which, for its first year, are estimated at $330,000.

Another important component of the Ministry's commitment to community-based care is the Homes for Special Care Program for patients no longer requiring intensive psychiatric care. More than 200 nursing homes provided placement for those needing extended or intermediate care, and more than 300 residential homes provided supervised accommodation for ex-psychiatric patients.

The Alcohol and Drug Abuse Program is also directed toward community-based services. In addition to the 15 detox centres across the province, over 15 other programs are funded. Among these programs are several which provide assessment and referral to appropriate programs.

The detoxification centre at St. Catharines, one of 15 centres scattered through the province



The Toanche Building at Penetanguishene Mental Health Centre is the centre's main treatment building, and contains four wards, with 32 to 38 beds each.

Dr. Gilbert Heseltine, Executive Co-ordinator, Mental Health Policy and Planning

Heseltine Appointed

Dr. Gilbert Heseltine was appointed to act as Executive Co-ordinator, Mental Health Policy and Planning, in May, 1981.

During his two-year mandate, he will review and assess current mental health services in Ontario and recommend policy directions for the development and delivery of these services for the future.

Dr. Heseltine has been seconded from the University of Western Ontario, where he is Chairman of the Department of Psychiatry and Chief of Psychiatry at University Hospital in London. He is known for his research work and for his studies of various health care policies with emphasis on the best use of rehabilitation services.

Psychiatric Hospitals

The Mental Health Branch operates 10 psychiatric hospitals across the province. Consistent with the shift toward community-based services, these hospitals have been developing outreach programs and providing back-up services to community programs.

Planning for the redevelopment of Whitby Psychiatric Hospital continued during the year with the completion of the Role Study and Master Program. Dr. Heseltine was asked to take part in the process and initiated a study of psychiatric care needs in the catchment area.

Several initiatives were taken at the Queen Street Mental Health Centre, Toronto, in response to the recommendations of a management consultant's report prepared by Peat, Marwick and Partners.

A three-member steering committee was formed in February, 1982, to act as a link between the Minister of Health and the centre, and to assist in implementing the recommendations of the report.

Chairman of the committee is Sister Janet Murray of the Sisters of St. Joseph Health Services Planning Committee. The other members are Dr. Robin Hunter of Sunnybrook Medical Centre and Basil J. Stevenson, QC, a hospital board member and past chairman of Peel Memorial Hospital in Brampton.

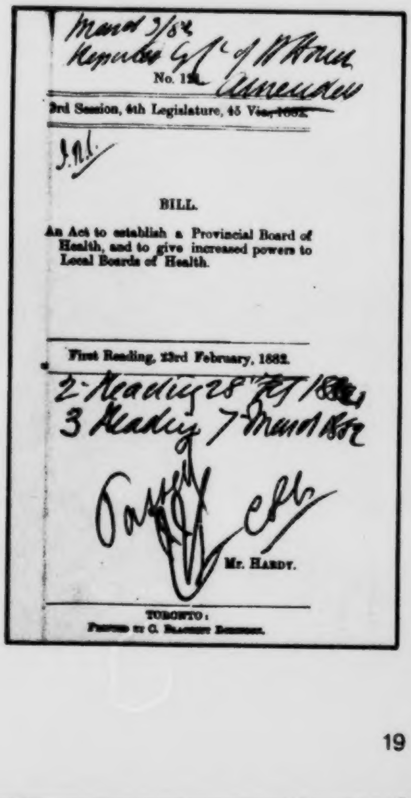
Michael O'Keefe, former Administrator of St. Thomas, North Bay and Whitby psychiatric hospitals, became the centre's new Administrator. On March 5, 1982, Dr. Samuel A. Malcolmson was appointed Psychiatrist-in-Chief and Clinical Director. The first priority was to assist the centre's administration put into effect the recommendations for improving community services contained in the management consultants' report.

At the time of his appointment, Dr. Malcolmson was a staff psychiatrist at the Clarke Institute of Psychiatry in Toronto and Associate Professor of the Department of Psychiatry at the University of Toronto.

Health Protection Act in Preparation

The *Public Health Act*, which prescribes public health services in Ontario, is approximately 100 years old. It has been amended from time to time, but fundamentally it has remained unchanged for many years. As a result, it does not truly reflect the role of the modern public health agency, and fails to provide a clear mandate to boards of health in the delivery of basic programs.

In order to provide a relevant legislative base, both now and in the future, the Ministry is preparing a new statute to be known as The *Health Protection Act*, now in its final stages of development. In July, 1981, a draft was sent to approximately 400 interested organizations and individuals. By the end of the year, approximately 200 submissions had been received and reviewed by Ministry program and legal staff. Appropriate amendments were made, and a final draft was ready for introduction to the Legislature early the following year.



March 3/82
Reported by C. of W. House
No. 1 amended

3rd Session, 4th Legislature, 45 Vic. ~~1882~~

BILL.

An Act to establish a Provincial Board of Health, and to give increased powers to Local Boards of Health.

First Reading, 23rd February, 1882.

2 Reading 28 Feby 1882
3 Reading 7 March 1882

Mr. Hardy.

TORONTO:
Printed by C. Blackett Robinson.

The Public Health Act of 1882, enacted a century ago

Surgeon Joins Underserviced Areas Plan

When physicians or patients in the Smooth Rock Falls area of Northern Ontario want the best possible advice on surgical procedures, all they have to do is call the local hospital. They can draw on the expertise of one of Canada's internationally renowned surgeons, Dr. Robert Mustard.

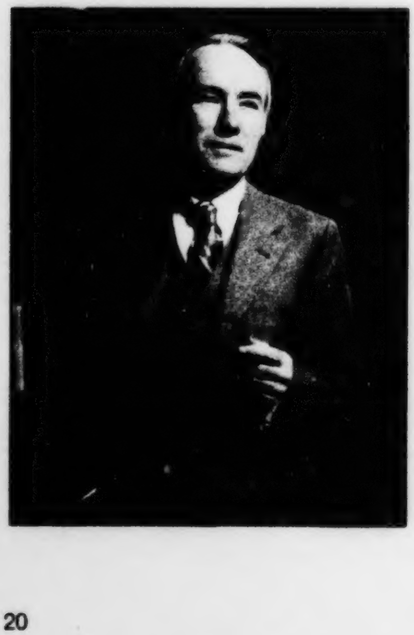
Dr. Mustard was Professor of Surgery at the University of Toronto and a mainstay of the Toronto General Hospital staff until he was persuaded to move to Smooth Rock Falls under the Ministry's Underserviced Areas program operated by the Public and Mental Health Services group.

Dr. W.J. Copeman, head of the Underserviced Areas program, says the presence of Dr. Mustard in the north proves the program is working. He calls Dr. Mustard a "super consultant" in surgery for a large area of the north.

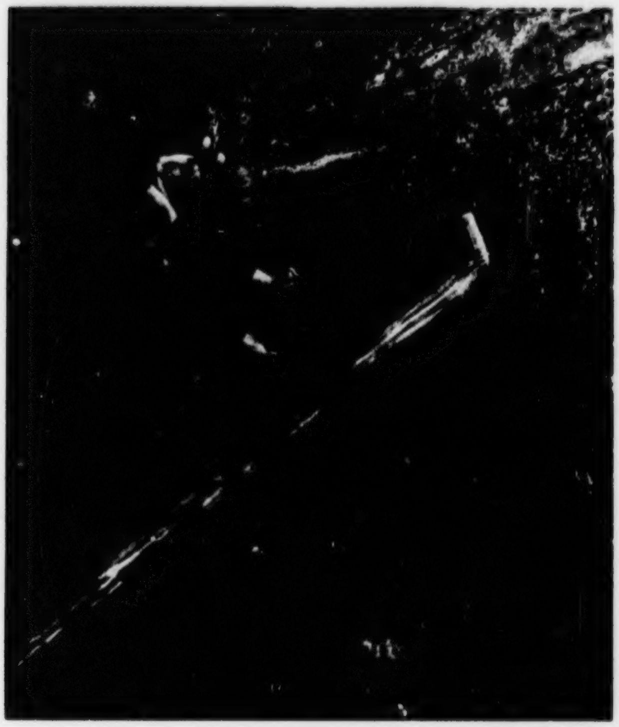
In the past few years, the Ministry has emphasized this special program, by doubling the tax-free grants for physicians and dentists who practise in officially designated underserviced areas.

Most of these are in mid-northern and northern areas, and have a need for doctors.

Excellent bursaries are provided by the Ministry of Northern Affairs and administered by this Ministry for students of both dentistry and medicine.



Dr. Robert Mustard, a well-known surgeon, has moved from Toronto to Smooth Rock Falls under the Ministry's plan to bring outstanding expertise to the province's underserviced areas.



During the early 1900's, as a result of findings in the hard rock mines of Ontario, mine owners agreed to replace dry drills with wet drills to cut down dust and reduce the incidence of lung disease among miners.

Underserviced Areas Program Adds Experts

Another in the Ministry's series of new and improved health services for Northern Ontario was this year's funding of four speech pathology and audiology programs in underserviced areas. Each program receives $40,000 annually (a total of $160,000) to hire audiologists and speech pathologists and provide them with ways of reaching those who most need their help.

The Ministry is committed to providing as much self-sufficiency in health care as possible in Northern Ontario. One of the ways it carries out this commitment is to encourage professional health care workers to establish in the north and to provide them with facilities to get around in what are usually vast areas with sparse populations.

The new speech pathology and audiology grants go to the areas of Muskoka-Parry Sound, Kenora-Rainy River, and Sudbury and Manitoulin Island, which will get both a speech pathology and an audiology program.

Ministry of Health

Ontario

Immunization Record

name

date of birth / year / month / day

An immunization card, which records a child's vaccination history

New Immunology Rules Give Added Protection to Children

Primary school children entering class for the 1981–82 school year got an extra dose of protection thanks to a new program which requires parents to provide information about their children's immunization history.

The Ministries of Health and Education, in consultation with the Ontario Medical Association, teamed up to launch the move in the continuing war against communicable disease. They give the parents a permanent immunization card on which to record the child's shots protecting him or her against polio, diphtheria, measles, rubella, mumps and tetanus.

The information collected from the families at school registration is kept by the local health unit. This allows the unit to tell parents when it is time to update their children's immunization.

Years of emphasis on immunization in Ontario have led to a protection rate that varies between 70 to 90 per cent for children entering school for the first time. But that rate still isn't good enough to prevent an outbreak of these diseases, which can produce severe complications.

As it has done historically, the Ministry provides vaccines free of charge, while the cost of administering the vaccine is covered by OHIP.

New Legislation for X-ray Safety

Legislation providing for the establishment of a five-member Healing Arts Radiation Protection Commission was proclaimed in force in August, 1981.

The commission was charged with developing an x-ray safety code, approving x-ray safety courses for operators, carrying out studies and advising the Minister of any other matters pertaining to x-ray safety.

None of the commission members are health professionals but the commission is supported by professional and technical committees.

Research Grants

From the Ministry's research programs, a total of $6.6 million was awarded to health research projects and personnel, including clinical and applied research, public health and health care systems research, and fellowships and research scientist support. The projects and personnel were sponsored by universities, hospitals, public health units and other health-related organizations. Studies were made of health problems and treatment for Ontarians from before birth (for example, the prenatal diagnosis of thalasemia) through to old age, with an assessment of chronic home care for the elderly.

The diagnosis and treatment of diseases such as hypertension and hepatitis was investigated. Health maintenance and promotion were examined with, for example, the development and testing of a program to prevent smoking in school children. In addition, aspects of the health care system were evaluated, including service needs of special groups such as hemophiliacs and patients on home dialysis, as well as education programs for health professionals.

A further $6.8 million supported the research programs of the following provincial research foundations: Addiction Research Foundation, Ontario Cancer Treatment and Research Foundation, Ontario Mental Health Foundation, Ontario Heart Foundation.

Lottery Funds for Research

Some of the real winners of Ontario's provincial lotteries could be people who suffer from ailments such as Alzheimer's Disease or Anorexia Nervosa, because proceeds from the lotteries are being used for research into these and other disorders.

Alzheimer's Disease is a particularly tragic mental deterioration that can begin in middle age. It is known as pre-senile dementia or premature aging of the mind, and can cause years of anguish to its victims and their families.

Anorexia Nervosa, or the dieting disease, strikes mainly at young girls. Essentially, the victim rejects food and suffers from severe weight loss. Sometimes this disease is fatal.

Researchers supported by the Ontario Mental Health Foundation are concerned about diseases like these. These two projects have been assisted this year by grants made by the Ministry to the Foundation, from the proceeds of the lotteries.

In the past six years, $25 million from the Provincial Lottery has been used by the Ministry of Health to foster and support research and development projects directed to the solution of priority health problems.

In this fiscal year, grants totalling $2,310,000 were given to eight Ontario health organizations including: the Ontario Thoracic Society, the Ontario Heart Foundation, the Canadian Foundation for Ileitis and Colitis (inflammatory bowel diseases), The Hospital for Sick Children Foundation, the Banting Research Foundation, the Ontario Cancer Treatment and Research Foundation, and the Arthritis Society, as well as the Ontario Mental Health Foundation.

The largest single grant was $500,000 for support in the development of a unit to co-ordinate clinical trials, to the Ontario Cancer Treatment and Research Foundation.

$500,000 for Diabetes Centre on 60th Anniversary of Breakthrough

In October, 1981, on the 60th anniversary of the discovery of insulin, a grant of $500,000 was made to the Banting and Best Diabetes Centre. The grant, from the proceeds of the Provincial Lottery, will provide $2 for every $3 raised by the centre from other sources.

The funds will be used for collaborative research by the University of Toronto and the University of Western Ontario into the cause, prevention and treatment of the long-term complications of diabetes, including the toxic side-effects of current treatment methods.

Dr. Charles Best (left) and Dr. Frederick Banting pose with Marjorie, the dog they used in their first experiments with insulin. Their discoveries, made exactly 60 years ago, have meant life for millions of diabetics.

Centre for Skin Diseases Launched in Toronto

Despite the fact that there are many chronic skin diseases that cause great pain and suffering, only limited research on skin diseases is being carried out in Canada or anywhere else.

On March 19, 1982, this changed significantly when Minister of Health Larry Grossman announced that the Ministry was providing a new research grant of $900 000 to the University of Toronto to establish a research and treatment program into chronic skin diseases. The program was established under the direction of Dr. Colin Ramsay, head of dermatology at Toronto General Hospital and Professor of Dermatology at the University of Toronto.

The researchers in the program are to study a number of skin disorders including the rare Epidermolysis Bullosa and its successful treatment by Pavel Kozak at his clinic in West Germany. This disease is one of the cruelest, causing severe blistering and fragility of the skin and dooming the sufferer to years of pain and isolation, or even death.

The Toronto General Hospital, The Hospital for Sick Children and Women's College Hospital have agreed to make their facilities available for the research program. McMaster University, the University of Western Ontario, and the University of Toronto also have agreed to take part through their collaborative training program for residents in dermatology, and Mr. Kozak has been offered a position as an advisor to the program.

In addition to the Kozak treatment, the program will study areas such as abnormal reaction to ultraviolet radiation and sunlight, as well as clinical pharmacology or the study of drugs and their relationships to the treatment of skin ailments.

First Phase of Kingston Move Sees 171 OHIP Jobs Relocated

From September, 1981, to the end of March, 1982, 171 positions within OHIP Head Office and its support services were relocated from Toronto to Kingston. This was the first step in the major move which will ultimately involve the relocation of 680 positions.

The move will be phased in over three years so that the Ontario Health Insurance Plan continues to provide good service throughout the relocation period, and so that staff may integrate gradually with the Kingston community.

Kingston was chosen as the new home for OHIP Head Office as part of the government's Go-East policy. It is hoped that decentralization will spur growth, and improve the economy in the Kingston area.

The annual payroll for these 171 positions is estimated at $3 million. As of March 31, 1982, the 171 employees, a mix of new personnel from the Kingston community and some relocated staff, were working out of three interim locations in Kingston while awaiting completion of the new OHIP headquarters.

Construction of the new provincial government building, which will house provincial courts and offices for the Ministry of the Attorney General, in addition to OHIP and its support services, went ahead on schedule. The Macdonald-Cartier Building, as it will be known, is due for completion by mid-1983. By the end of March, 1982, the building was fully enclosed and work had begun on the interior.

Detailed plans for the relocation of OHIP and support services positions to interim locations in Kingston were developed during 1981–82. By the end of calendar year 1982, 75 per cent of OHIP's Head Office will be in Kingston. The final move of remaining positions from Toronto to Kingston, and of staff from all Kingston interim locations into the Macdonald-Cartier Building, will be carried out in 1983. As well, OHIP's computer functions will be moved from Toronto to Kingston in 1983.

New headquarters for staff of the Ontario Health Insurance Plan. OHIP's move from Toronto is an important part of the government's decentralization program.

Dr. J.T. Phair, medical officer of health, examines newly vaccinated children in rural Ontario during the 1940's.

In Toronto, approximately 200 employees who were unable or unwilling to relocate with their jobs were reassigned to other positions within the Ontario Public Service in Metropolitan Toronto from April, 1981, to the end of March, 1982. Remaining Toronto staff are continuing to be reassigned under a program conducted by the Ministry of Health and the Civil Service Commission.

The Relocation Project is restricted to the Head Office of OHIP, and does not involve the operations at the district offices throughout the province.

Doctors' Fee Negotiations Use Factfinder Approach

Professor Paul Weiler was appointed Chairman of the Joint Committee on Physicians Compensation for Professional Services under OHIP. At the time of that appointment, Professor Weiler was MacKenzie King Professor of Canadian Studies at Harvard Law School.

After negotiations between the Ministry and the province's physicians reached an impasse in April, 1981, Professor Weiler was asked by both sides to act as a factfinder and make recommendations for a settlement. Both the Ministry and the Ontario Medical Association accepted his recommendation as to the annual increase in the overall schedule of benefits under the Ontario Health Insurance Plan. The OMA made the detailed allocation of the individual benefits within the schedule as called for by the agreement.

Auditors Promote Efficiency

Efficiency and effectiveness have become key watchwords of governments in recent years because of dramatic changes in the economic climate.

The Ministry's Audit Branch worked to improve both these aspects during the year. Its programs provide comprehensive audit services to the internal organization of the Ministry, to outside agencies, and to health institutions that receive transfer payments or grants from the Ministry.

The branch also made adjustments in staff training and development programs with a view to improving the efficiency and effectiveness of the audit process.

The other area of improvement was in auditing of the Ministry's computer applications, an ultra modern field that is constantly changing and expanding.

District Health Councils

District Health Councils plan and co-ordinate local health care services in response to local needs. They identify area health needs, weighing alternatives, establishing priorities and planning many comprehensive health care programs for their districts, working within the Ministry's policy framework.

The District Health Council Program is made up of an executive director and an area planning co-ordinator for each of the six geographical areas of the province. They are the Ministry's primary liaison with the district health councils, and help them to involve their own communities in health care planning.

A total of 25 district health councils have been established, serving more than 90 per cent of Ontario's population.

District health councils are made up of volunteers, and balanced so that they are truly representative of their area. They include men and women who may be health professionals, individual citizens, or local government representatives, some of whom may live in rural and some in urban areas. Members are appointed by an Order-in-Council for terms of one, two, or three years, with a maximum of two three-year terms.

Since councils were first appointed, they have helped to consolidate health services, improve patient care, organize shared service requirements, and more effectively direct valuable funds. Among areas they have surveyed and studied are: bed accommodation; dental health care; needs for the elderly; long-term care; rationalization of laboratory services; district health care; district institutional roles; mental health services; hospital proposals for new and expanded programs; and morbidity and mortality.

In future, district health councils plan to conduct district-wide health service studies and develop long-term health service plans. They hope to help co-ordinate services, and provide a balanced system, working with other agencies and ministries to plan the co-ordinated delivery of social services at the district level.

New Program to Train Future Ministry Managers

New trails were broken in the Ministry when eight interns entered a two-year program intended to train and develop future managers.

Some of the eight were drawn from the Ministry itself while the others were recruited from university graduating classes in business, public administration, and hospital administration courses.

During the program, the trainees are given three-month assignments in eight different parts of the Ministry. They get both line management and staff experience and they each have a mentor, a senior management person, to guide them through the training program.

At the end of two years, the trainees are expected to compete for middle management and key staff jobs in the Ministry.

Women Break Tradition

Affirmative Action recorded promising breakthroughs in the Ministry this year as women were appointed to jobs that had been the traditional and exclusive domain of men.

These pioneering women moved into positions in general administration, personnel administration, purchasing and supply, institutional care, and equipment operation that have not been held by female workers before. In addition, one woman became a construction inspector, another became an agricultural worker (working with animals at the Central Laboratory in Toronto), and one became an operator of offset equipment.

Another 22 women moved into classifications that had been targeted as priority positions by Affirmative Action. These targeted classifications, into which women had not made sufficient inroads, ranged from general administration jobs to ambulance officers.

The Ministry also met its objective of having women comprise at least 30 per cent of the workforce in a further five classifications.

Affirmative Action also made sure that women in the Ministry should have ample support in their search for new skills and new assignments. At 58 workshops and skill sessions, 826 women could learn management skills, résumé writing, interview techniques, assertiveness, self-assessment and skills identification, and take advantage of career counselling.

The Affirmative Action program provided other workshops, conferences, training sessions, and publications to help women in the Ministry.

A new management training program began this fiscal year. Pioneers of this two-year management internship program are: (standing left to right) Janet Doering, Mary Sullivan, Tim Little, Bonnie Linkletter, (seated) Kevin Quinn and Ruth Armstrong.

Filling a Ministry position that has traditionally been a man's job is Merosia Davies, Building Program Co-ordinator, Mental Health Branch.

Services en langue française

Le ministère s'est par le passé formellement engagé à instituer un ensemble complet de services de santé en langue française, à commencer par les régions de l'Ontario ayant d'importantes concentrations francophones. Cette politique s'applique à toutes les directions, tous les services et toutes les sections du ministère et affecte des secteurs aussi variés que ceux des communications orales et écrites, de l'embauche de personnel bilingue lorsque cela s'avère essentiel ou souhaitable, du programme de formation du personnel en français, de l'affichage bilingue et des publications en langue française.

Dans le but d'atteindre pareils objectifs, le Bureau des services de santé en langue française a donc vu le jour en 1978. De fait, dans les grandes lignes, son mandat est de veiller à l'amélioration et à la consolidation des services offerts aux francophones dans le domaine de la santé.

En vue d'encourager notamment les hôpitaux à offrir des services en français, le ministère a octroyé, pour l'année en cours, quelque 504 000 $ répartis entre 49 hôpitaux publics situés à l'intérieur de 16 régions désignées, ainsi qu'à Toronto et Hamilton, une augmentation de 32 000 $ sur l'année précédente. Avec de tels fonds, ces hôpitaux sont désormais en mesure de mettre en place des programmes de formation linguistique qui permettent aux membres du personnel de l'hôpital de pouvoir fonctionner en français.

Huguette de Repentigny Larkin, Infirmière coordinatrice à l'Accueil Médical Francophone

D'ailleurs, une conseillère en formation linguistique, spécialiste en phonétique, a été embauchée pour évaluer les cours de français au sein du ministère et dans les hôpitaux. Cette évaluation est offerte gratuitement.

De même, à ce niveau de l'enseignement du français, des fonds de 50 000 $ ont été octroyés à la Direction des ressources humaines pour la mise en oeuvre d'un programme intensif de cours de français destinés aux employés du ministère occupant des postes-clef à Ottawa, Sudbury, North Bay, Thunder Bay, Timmins et Toronto.

Aussi, puisqu'effectivement l'un des problèmes majeurs les plus fréquemment rencontrés en ce qui regarde les services de santé à la communauté francophone est la rareté du personnel apte à fonctionner en français, le ministère entend prendre des initiatives pour inciter un plus grand nombre de jeunes étudiants francophones à faire carrière dans le domaine de la santé, tout en les encourageant à s'établir dans les régions désignées, c'est-à-dire dans le Nord de la province. A ce niveau, un programme d'aide financière a notamment été établi par le ministère, en collaboration avec le ministère des Affaires du Nord, afin d'encourager

La campagne entreprise afin de faire connaître les services en français du ministère avait pour slogan: "Notre but, vous servir en français". Ce slogan est apparu sur une affiche, sur une brochure et dans une annonce publiée trois fois dans les hebdomadaires en langue française.

les étudiants en art dentaire et en médecine à étudier dans les universités du Nord et, par la suite, à s'y établir. Prochainement, une tournée des écoles secondaires en régions désignées sera entreprise afin de sensibiliser les jeunes aux besoins et problèmes de la population francophone en matière de service dans le domaine de la santé.

Le ministère ne ménage pas ses efforts pour encourager ses bureaux à offrir des services en français. Pour 1981–82, il avait notamment versé 100 000 $ à des unités sanitaires à l'intérieur des régions désignées pour les aider à améliorer leurs services dans la langue de Molière. Par ailleurs, en collaboration avec le ministère des Affaires du Nord, une subvention de 140 000 $ a été versée par le ministère au Centre des pionniers pour qu'il puisse établir un centre d'information médicale francophone, baptisé l'Accueil médical francophone, à Toronto. Cet établissement servira non seulement les francophones de la ville mais bien également ceux qui auront à séjourner dans la capitale, puisqu'il s'est donné comme mandat d'offrir des services d'interprétation, de traduction et d'orientation, à la clinique, à l'hôpital ou aux bureaux des médecins, aux patients francophones séjournant à Toronto.

Dans le même ordre d'idées et ayant cette fois-ci pour objectif de venir en aide et aux hôpitaux et aux services de santé publique, le ministère avait octroyé, pour 1981–82, la somme de 52 000 $ pour la traduction de formulaires, de publications et de documents destinés aux patients, notamment en ce qui concerne le Régime d'assurance-maladie de l'Ontario (OHIP/RAMO). Sera également traduit prochainement un document audio-visuel d'information préparé par l'Université de Toronto concernant la préparation et la manipulation, par le personnel médical, d'un médicament employé dans la lutte contre le cancer.

Toujours pour assurer de meilleurs services à la communauté francophone, le ministère a aussi versé, pour l'année en cours, des subventions de 10 000 $ au "Family and Patient Communication Centre of Ottawa" pour défrayer les coûts de la traduction de renseignements généraux destinés au public, et de 1 500 $ au Collège Algonquin d'Ottawa pour qu'il entreprenne la traduction de l'examen national de technologie respiratoire.

Par le biais de son Bureau de services de santé en langue française, il se met donc à l'écoute de la population francophone de la province en organisant des colloques, telle la rencontre inter-régionale de Timmins sur les services de santé en langue française dans le Nord de l'Ontario, colloque pour lequel quelque 3 500 $ furent versés à l'A.C.F.O. régionale de Timmins par l'entremise de son bureau provincial, et également le colloque tenu à Ottawa dont l'objectif était de susciter des réactions et des suggestions visant à améliorer la qualité des services de santé en français dans l'Est ontarien. A ce chapitre, il faut aussi souligner que notre bureau des services français prévoit, pour très bientôt, la tenue d'un autre de ces colloques dans le Nord de la province.

Enfin, sachant fort bien qu'il est important de faire connaître à la population francophone les services qui lui sont offerts dans sa langue, le ministère, en collaboration avec le Bureau du coordonnateur provincial des services en français, a visité plusieurs régions à forte concentration francophone, dont les villes de New Liskeard, Hearst, Kapuskasing, Sturgeon Falls, Penetanguishene, Welland, Cornwall, North Bay et Mattawa, dans le but d'informer la population francophone et de l'inciter à utiliser les services en français.

Wizards, Rock 'n' Roll and Mime Encourage Kids to Stay Healthy

"I thought your play was really good; my favorite part was when you made up a plan to get the evil out of the wizard . . . .The wizard realized he should get more exercise, more rest and only eat junk food when it's necessary. I really like that play."

That enthusiastic critique from a child who had just seen the Ministry's mime and puppet show was characteristic. The show, promoting healthy living habits for kids, took to the road this year and was such a hit, it went into a second season.

Children have long been the primary "customers" for the product being marketed by the Health Promotion and Information Branch of the Ministry. That product is good health brought about, mainly, by good living habits formed during childhood. Although the Ministry has many programs that reach adults and promote better health, it is in the minds and bodies of children that much of the war against poor habits has to be won. It was in this area that the branch concentrated its resources during the year.

The show starring the reformed wizard is the latest in a long series of shows, displays, exhibitions and promotions teaching the youngsters of Ontario good habits. In fact, it was the Ontario Ministry of Health and its predecessors that pioneered travelling health promotion exhibitions in North America. Some of its shows were so successful, neighboring provinces and states asked for and received visits.

In the March break and other school holiday periods during the year, 120 performances were seen by more than 25,000 children in all parts of the province.

Through mime, puppetry and musical vignettes, the show helps children from eight to 11 learn about nutrition, exercise, getting enough sleep, drinking alcohol only in moderation and the importance of not smoking.

The show highlights an evil old wizard who casts a spell on a child so he will be tempted into poor health habits. The child in the play breaks the spell and convinces not only himself and the wizard but the audience too, that a healthy lifestyle "makes you feel better."

As another young member of the audience put it after the show, it was "just super . . ."

The mime and puppetry show was only one of the methods used by the Health Promotion and Information Branch to get its health messages to the people of the province.

The Ministry also focused on encouraging teenagers to avoid the smoking habit in its "Feelin' Good" exhibit, in a repeat season this year. The exhibit relies on a bit of fun, rather than a heavy-handed approach, in getting its theme across to teens.

One of the more popular parts of the display was the Butt Stop where kids could sit and listen to a recorded tape of a smoker's hacking cough, play an electronic game called "Run for your Life" or see displays stressing the need for people to take personal responsibility for their health and lifestyle habits.

This positive way of promoting health is also used in promotions such as the Food for Health contest initiated two years ago. This contest is for Ontario high schools, whose students can come up with ideas and action in a war against junk foods.

This year the contest was based on an Eat Sensibly theme and the school with the best program was offered the services of a rock group for a dance, plus a $1,000 award for its student council. Other prizes were also given.

Each year students think up ideas ranging from free nutritious snacks for fellow classmates to changing cafeteria menus, imaginative quizzes, skits, and slogans on T-shirts.

The wizard and fellow actors from Health Spell, a travelling play that teaches children good health habits while entertaining them

Ontario Council of Health

Established in 1966, the Ontario Council of Health is an autonomous organization that functions under the Ministry of Health Act. Its duty is to advise the Minister on the health needs of the people of Ontario. Council provides the Minister with independent and impartial advice on a variety of health-related issues. In doing so, its emphasis is on long-range perspectives although not to the exclusion of more immediate policy issues of importance.

Council is completing a major study on smoking, and another study on high technology diagnostic imaging facilities and equipment. It has provided the Minister with advice concerning the role of denture therapists and dentists with particular reference to the supply and installation of partial dentures.

Other studies are being carried out by task forces and in-house research staff to assist Council in its policy-advisory role. These include a review of laboratory services, aspects of health services utilization, computer systems in the health care sector, and issues relating to health research and development.

A major new initiative during the past year has been a review of medical manpower issues in Ontario, with initial emphasis on post-graduate specialty training, and the impact of these programs on medical manpower questions, particularly in the context of health services in general.

Timbrell Leaves

On February 13, 1982, after five years as Minister of Health, Dennis R. Timbrell was appointed Minister of Agriculture and Food and turned this Ministry over to Larry Grossman. In the five years during which he presided over the Ministry of Health, Mr. Timbrell introduced and developed programs which have become not only a permanent part of the Ministry but a lasting contribution to the health care system of the province.

Among the highlights of Mr. Timbrell's record as head of the Ministry of Health, is the air ambulance service which he initiated and expanded. In addition, under Mr. Timbrell's direction, the government used lottery funds to aid hospital construction projects. This move secured an additional $100 million for hospital capital. He also revised Ontario's Nursing Home Regulations to ensure higher levels of patient care. Also in the area of legislation, he pioneered revisions to the public health system.

It was under Mr. Timbrell's direction that the province's regional perinatal care program was instituted. To further increase health protection for children, he worked to improve provincial immunization levels, which led to the present compulsory immunization program.

It was Mr. Timbrell who introduced experimental projects in telemedicine and who introduced and later expanded, province-wide, the poison prevention program for parents of pre-school children.

Former health minister Dennis R. Timbrell sits in the cockpit of Bandage 1, the Ministry's first air ambulance, with Susan Davis, winner of the name-the-helicopter contest. Mr. Timbrell left the Ministry in February to take up his new appointment as Minister of Agriculture and Food.

Statement of Revenue and Expenditure For The Year

Expenditure	
Ministry Administration Program	
Main Office	5,117,272
Financial Services	6,459,170
Supply and Office Services	9,286,998
Personnel Services	2,835,648
Information Services	3,981,959
Analysis and Planning	427,935
Legal Services	545,088
Audit Services	1,288,597
Research	18,197,408
Systems Development Services	13,590,236
Total	61,730,311
Institutional Health Services Program	
Program Administration	293,789
Psychiatric Services	268,409,811
Emergency Health Services	83,100,418
Institutional Care Services	3,431,278,298
Laboratory Services	18,572,805
Experience '81	256,633
Total	3,801,911,754
Community Health Services Program	
Program Administration	278,216
District Health Councils	6,159,086
Health Programs	187,497,253
Total	193,934,555
Health Insurance Program	1,754,975,468
Total Expenditure	5,812,552,088
Revenue	
Contributions: Government of Canada	10,504,067
Premiums: Ontario Health Insurance Plan	1,179,077,000
Loans to Public Hospitals	17,477,974
Miscellaneous	48,705,692
Total Revenue	1,255,764,733

Summary of OHIP Medical Activities

Enrolment	Certificates		Participants	
Average number of certificates and participants during 1981/82				
Single	1,773,217	(43.2%)	1,773,200	(20.6%)
Family	2,333,293	(56.8%)	6,818,800	(79.4%)
TOTAL	4,106,510		8,592,000	
Groups	2,227,398	(54.2%)	5,399,300	(62.8%)
Full pay	455,231	(11.1%)	998,300	(11.6%)
Partially assisted	2,953	(0.1%)	5,300	(0.1%)
Fully assisted	236,285	(5.8%)	379,600	(4.4%)
Temporary assisted	39,311	(1.0%)	66,100	(0.8%)
65 and over	880,530	(21.4%)	1,235,800	(14.4%)
D.V.A.	19,991	(0.5%)	39,500	(0.4%)
Municipal welfare	87,348	(2.1%)	161,700	(1.9%)
Provincial welfare	157,463	(3.8%)	306,400	(3.6%)
Total Claim Payments Paid during year	$1,543,010,863			

Service distribution (all payments)	
Medical	$1,422,557,001 (92.2%)
Dental	5,854,626 (0.4%)
Optometric	25,054,826 (1.6%)
Chiropractic	36,878,971 (2.4%)
Osteopathic	402,627 (—)
Chiropody	3,748,979 (0.2%)
Physiotherapy	10,105,892 (0.7%)
Out of Province Hospital	38,407,941 (2.5%)

Mode of Payment (Based on claims payments)	Physician %	Subscriber %
Medical	89.9	10.1
Dental	98.1	1.9
Optometric	96.5	3.5
Chiropractic	98.2	1.8
Osteopathy	96.4	3.6
Chiropody	89.8	10.2
Physiotherapy	100.0	—
Overall	90.3	9.7

Revenue	
Net premium revenue for combined plan	$1,179,077,000

Summary of Public Hospital Care

All Public Hospitals in Ontario	Year ended March 31/82*	Year ended March 31/81	Percentage Increase (Decrease) 1982/81
Approved Beds	48,668	47,615	2.2
Number of:			
Admissions	1,279,916	1,277,794	0.2
Discharges and deaths	1,278,843	1,277,323	0.1
Patients under care during year	1,322,190	1,319,597	0.2
Total patient days:			
Discharges and deaths	15,020,550	14,597,230	2.9
Care given during year	15,050,578	14,769,248	1.9
Average length of stay:			
Acute	8.6	8.7	(1.1)
General rehabilitation	36.3	37.5	(3.2)
Chronic	260.7	220.9	18.0
Psychiatric**	38.1	34.6	10.1
Alcohol and drug addiction***	27.5	27.9	(1.4)
Special rehabilitation	43.3	42.7	1.4
Overall average	11.7	11.4	2.6
Number of radiological examinations:			
In-patients	1,828,612	1,814,099	0.8
Out-patients	3,643,323	3,489,773	4.4
Total units of laboratory service in hospitals:			
In-patients	417,021,822	408,444,488	2.1
Out-patients	190,551,670	176,600,250	7.9
Referred-in	56,616,377	53,260,938	6.3
Routine health	141,603,555	136,419,610	3.8
Total staff and employees of hospitals:			
Full-time	97,422	96,172	1.3
Part-time	36,192	33,082	9.4

*1982 data is preliminary for the fiscal year ending March 31, 1982.

**Refers to Clarke Institute only. Psychiatric units included in Acute.

***Refers to Donwood Institute only.

Vaccine Distributed

Vaccine Distributed	Doses Distributed	Dollar Value
Diphtheria Toxin Schick Test (SCREEN)	67,260	24,711
Diphtheria Toxoid (STAR)	9,501	14,979
Diphtheria Toxoid (LIGHT)	15,730	18,323
Diphtheria Toxoid (ROCKET, COMET)	3,965	3,064
Diphtheria Toxoid, Pertussis and Tetanus (EARTH)	101,130	140,990
Diphtheria Toxoid, Tetanus Toxoid (TURF)	13,700	13,131
Pertussis Vaccine (WHOOP)	6,715	9,720
Rabies Vaccine (HUMAN DIPLOID)	8,378	417,311
Tetanus Toxoid (GRAIN)	256,340	386,869
Tetanus & Diphtheria Adsorbed	3,730	5,929
Diphtheria Antitoxin (FAWN)	80	4,397
Tetanus Antitoxin (BIRCH)	0	0
Rabies Antiserum (HORSE SERUM)	310	11,470
Diphtheria, Tetanus, Pertussis & Polio Vaccine (QUAD)	626,285	2,162,649
Diphtheria, Tetanus & Polio Vaccine (TRIAD)	376,450	1,269,599
Tetanus and Polio Vaccine (BIAD)	399,970	1,263,330
Polio Vaccine Oral (SABIN)	16,010	14,832
Polio Vaccine Unigen (LAKE)	228,820	741,761
Rabies Vaccine (RABBLE)	1,442	136,066
Rabies Immune Serum (HUMAN)	1,907	158,418
Rabies Tissue Culture (RACE)	294	5,400
Antivenin	35	1,019
Rubella	36,750	74,289
Duck Embryo	125	691
Measles-Mumps-Rubella	252,220	785,892
Rifampin	15	630
TOTAL	2,411,152	7,650,638

Ministry Staff Strength

Full Time	
Branches	3,977
Psychiatric Hospitals	7,068
TOTAL	11,045
Part Time	
Branches	99
Psychiatric Hospitals	686
TOTAL	785
COMBINED TOTAL	11,830

Inventory of Approved Institutional Beds

	As at March 31/82*	As at March 31/81
Public Hospitals		
Acute**	36,324	35,969
Chronic***	12,344	11,646
	48,668	47,615
Private Hospitals		
Acute	322	372
Chronic	525	525
Nursing Homes	28,686	28,295
Homes for the Aged****	12,911	13,118
Total of all Institutions	91,112	89,925

*Subject to audit
**Acute includes psychiatric beds
***Chronic includes special and general rehabilitation beds
****Extended care only

A CENTURY OF CARING

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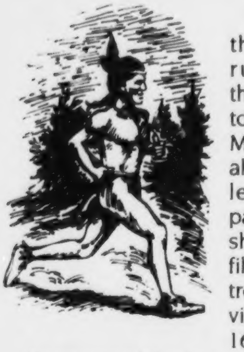
PROLOGUE



With an easy lope, the Huron brave runs steadily through the forest toward his village. Muscles ripple along his back and legs and, as he passes through the shafts of sunlight filtering through the trees, he glows with vigor. The year is 1610, and it would be written of this brave and thousands like him that he was a "robust" man, much taller than the Europeans who would soon arrive on his shores.

The Hurons recognized three types of sickness: sickness due to natural causes and cured by such natural remedies as wild sarsaparilla and "Indian turnip"; sickness caused by the desires of the soul and cured by consulting dreams; and sickness caused by witchcraft and cured by the medicine man.

Magic and roots, dreams and incantation they might have been, but together they represented an approach to health care that had given the Hurons a life span of nearly 40 years and freedom from the common diseases which struck down the more "civilized" beings half a world away. But neither drugs nor dreams nor the medicine man could stop the diseases that white people would bring or heal the wounds inflicted by the axes and spears of the Iroquois.

Within 40 years, the Hurons would be driven from their lands. Gone with them would be a health care system that had served for thousands of years. It would not be replaced by another whole system for two and a half centuries.

The first records of modern medicine in Ontario date from 1639. In that year, the religious order of Jesuits established a permanent headquarters for their ill-fated Huron Mission on the east bank of the Wye River, close to the present-day town of Midland. Over the next 10 years, this settlement grew to become a fortified town covering almost three acres. Today, of course, we know it as *Sainte-Marie Among the Hurons*.

Within the walls of the settlement, 66 Frenchmen — priests, lay brothers, soldiers and artisans — were served by two chapels, a blacksmith shop, a cookhouse, a cemetery, and the first hospital in Ontario. Neither the hospital nor the settlement lasted. In 1649, the Iroquois, coming from the south in search of beaver skins, attacked the Hurons and the Jesuits and drove them from the area that is now Simcoe County. The forests grew up again over the clearings of the Huron settlement and covering the ruins of the primitive hospital hut at Sainte-Marie Among the Hurons.

More than 130 years would pass before the forests would be cleared again by other inhabitants. In 1784, the British-Americans who refused to join with the American rebels in the Thirteen Colonies were forced to flee and seek asylum in Upper Canada.

Among the refugees, there were few who knew anything about surgery and medicine. When they were sick, the United Empire Loyalists turned to the few surgeons at the military garrisons at Kingston, Niagara and Detroit. For many years they were dependent on this handful of military surgeons who were often reluctant to leave their fortifications to visit the sick.

The demand for medical care that was created by the arrival of the United Empire Loyalists in Upper Canada attracted a small army of quack doctors who travelled north from the United States. Few of them possessed any medical skill, but all of them professed to be able to cure all diseases with two "specifics" — opium and mercury.

The Reverend, later Bishop, John Strachan wrote about such charlatans under the pseudonym "Reckoner," in the *Spectator*:

> "The Province is overrun with self-made physicians who have no pretentions to knowledge of any kind, and yet there is no profession that requires more extensive information. . . .
>
> "I was called to a young man whose disease, a dysentery, had been much aggravated by the gross ignorance of his physician. This profound doctor had the audacity to say, after my arrival, that the youth was getting better when he was in the very agony of death and actually expired in a few minutes."

Another blatant example of charlatan practice was contained in a letter in the *Kingston Gazette* of June 2, 1812. It referred to a bill submitted by a "doctor" to the parents of a patient. The bill noted a deduction from the fee of six pounds for "killing your son," an apparent admission on the part of the "doctor" that he had transmitted smallpox to the boy.

A *Huron medicine man, driving away evil spirits*

Part of the reconstructed Sainte-Marie among the Hurons. The seventeenth century settlement was the site of Upper Canada's first hospital, and included a cookhouse, a blacksmith shop, two chapels and a cemetery.

The blight of quackery spread with the growth of towns and villages, and in 1788, Acts were passed in the Parliament of Great Britain prohibiting the practice of medicine, surgery or midwifery without a licence in Upper Canada. The penalties were severe, ranging from a first-offence fine of twenty pounds to 100 pounds and three months' imprisonment for a third offence.

Unfortunately, the Act hurt Good Samaritans more than charlatans. It left open to penalties the neighbor woman who assisted at a birth or the farmer who gave a friend help in lancing a boil. Countless repeals and new acts followed up to 1818, during which the medical frauds continued to be perpetrated throughout Upper Canada.

In 1818, an Act was passed that is regarded as the first practical step in licensing people in the medical profession in Upper Canada. The Act set up a board of five practitioners who were to meet twice a year and examine all those who wanted to practise "physic, surgery and midwifery, or any of them, within this province. . . ." The board was kept busy, and instead of meeting the specified two times a year, it met every three months.

One of the members of the first Medical Licensing Board was Dr. Christopher Widmer, regarded as the father of surgery in Upper Canada.

There is no question, however, that the first real physicians in the land that became Ontario were the British army surgeons; and except for the primitive hospital at Sainte-Marie Among the Hurons, and a little-known hospital for Indians at Sault Ste. Marie, the first hospital in Ontario was very likely located in the military garrison at Kingston.

In 1802, a report describing the military buildings in York (Toronto) was published. Among the sheds, blockhouses, "hutts" and other wooden buildings for 224 men, there were "two Officers' hutts for an hospital."

In 1812, war came to North America. To the British, already locked in combat with Napoleon in continental Europe, this "American War" was a sideshow; but, to the people of Upper Canada and the 40 or so truly qualified medical men in the colony, it was a real and bloody conflict. The doctors who would later serve on the first medical licensing board of Upper Canada practised their calling under appalling battle conditions in Niagara, York and Kingston.

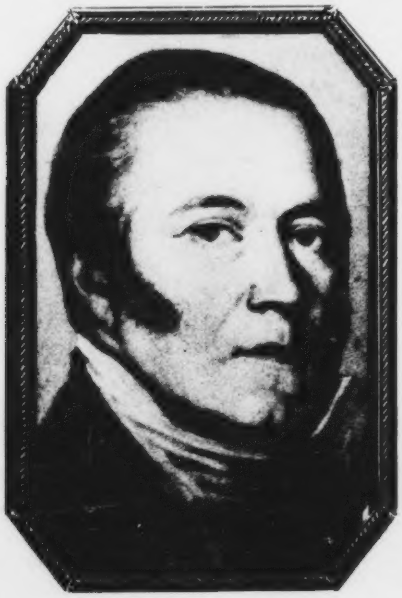
Reverend Strachan acted as a first-aid man when York was under American attack. When the garrison hospital was blasted to pieces by Yankee cannon and the consequent explosion of a powder magazine, Strachan evacuated 50 wounded men and helped dress their wounds.

United Empire Loyalists fleeing to Upper Canada in the late 1700s

William 'Tiger' Dunlop, one of Ontario's most famous pioneer doctors, and a hero of the War of 1812

Dr. William "Tiger" Dunlop, who would later found the town of Goderich, Ontario, served in the War of 1812 as Assistant Surgeon to the 89th Regiment of Foot. In his *Recollections of the American War, 1812–1814*, he gave a first-hand account of the treatment of the wounded while under attack:

> "Accordingly, upon inquiring where my wounded were to be put, I was shown a ruinous fabric, built of logs, called Butler's Barracks, from having been built during the revolutionary war by Butler's Rangers for their temporary accommodation. Nothing could be worse constructed for an hospital for wounded men — not that it was open to every wind that blew, for at midsummer in Canada that is rather an advantage; but there was a great want of room, so that many had to be laid on straw on the floor, and these had the best of it, for their comrades were put into berths one above another as in a transport or packet, where it was impossible to get round them to dress their wounds, and their removal gave them excruciating pain.
>
> ". . .I found myself in charge of two hundred and twenty wounded, including my own Regiment, prisoners and militia, with no one to assist me but my hospital serjeant, who, luckily for me, was a man of sound sense and great experience, who made a most able second; but with all this the charge was too much for us, and many a poor fellow had to submit to amputation whose limb might have been preserved had there been only time to take reasonable care of it. But under the circumstances of the case it was necessary to convert a troublesome wound into a simple one, or to lose the patient's life from want of time to pay him proper attention.
>
> ". . .I never underwent such fatigue as I did for the first week at Butler's Barracks. The weather was intensely hot, the flies were in myriads, and lighting on the wounds, deposited their eggs, so that maggots were bred in a few hours, producing dreadful irritation, so that long before I could go round dressing the patients, it was necessary to begin again; and as I had no assistant but my serjeant, our toil was incessant."



Reverend John D. Strachan, later Bishop Strachan, when he was principal of Home District Grammar School in Toronto (1812–1823). He wrote angry articles attacking the quack doctors who followed the United Empire Loyalists north.

There were many stories of medical experiences during the war. Dr. William Lee wrote of retreating with the army after the American capture of York to Kingston, walking all the way as he tended the wounded in his care. Upon reaching Kingston, the doctor was ordered back to York and had to retrace the whole distance once again on foot — more than 150 unpaved miles each way.

The war made this "dirty, straggling village of 60 houses" called York the medical headquarters for the Niagara region. After the war, York became a hospital centre as well. In 1815, a proper military hospital was built in the York garrison that continued in service until the 1850s; and by 1865, there were five hospitals in the district of Stanley Barracks, a hospital boom that led the way to today's hospital row along University Avenue in Toronto.

One of the early hospitals was the first general hospital in Upper Canada and was literally built on a foundation of gold and silver. The Loyal and Patriotic Society of Upper Canada had been founded at York to help disabled militia men and their families and to grant medals for bravery in defence of the province. Unfortunately, it could never be decided exactly who among all the many brave candidates deserved the coveted medals and they were never distributed. The medals were melted down and the bullion went in part toward the building of York General Hospital. Construction began in 1820 and the hospital was completed in 1824. Today it is known as Toronto General Hospital.

The driving force behind the establishment of York General Hospital was Dr. Christopher Widmer. He was a remarkable teacher and developed the hospital into a major teaching and research centre. It will be remembered that Dr. Widmer was a member of the first medical licensing board, established in 1818. In 1839, he became president of the College of Physicians and Surgeons.

Dr. Christopher Widmer played a leading role in the establishment of York General Hospital, and was considered the father of surgery in Upper Canada. He was a member of the first Medical Licensing Board. During the years immediately following the War of 1812 he was one of the few qualified doctors in York.

Dr. James Miranda Barry, who became Inspector General of Hospitals in the Canadas in 1857. When she died in 1865, it was discovered that she was a woman.

There were many dedicated and intelligent doctors and lay people who contributed much to medicine during the early years of health care in Upper Canada. A startling example was Dr. James Miranda Barry. After a busy and distinguished career throughout the world, this small, delicately built, unassuming doctor was appointed Inspector General of Hospitals in the Canadas in 1857. Dr. Barry found serious sanitary problems in the military posts at Kingston and Toronto as well as Quebec. In one instance, troops were using the urine tubs to wash in and were developing eye infections as a result.

Dr. Barry's advanced ideas about sanitation and health led to changes in sewage and drainage systems. The doctor introduced water pipes in place of the wells that froze in the winter and recommended changes in diet which provided more fresh meat in place of salt pork and boiled beef.

Widespread drunkenness among the troops was thought to stem from a lack of separate accommodations for married men and their families. The doctor suggested that a room for each family would diminish the problem of intemperance.

Dr. Barry called for libraries with a good selection of books for the soldiers.

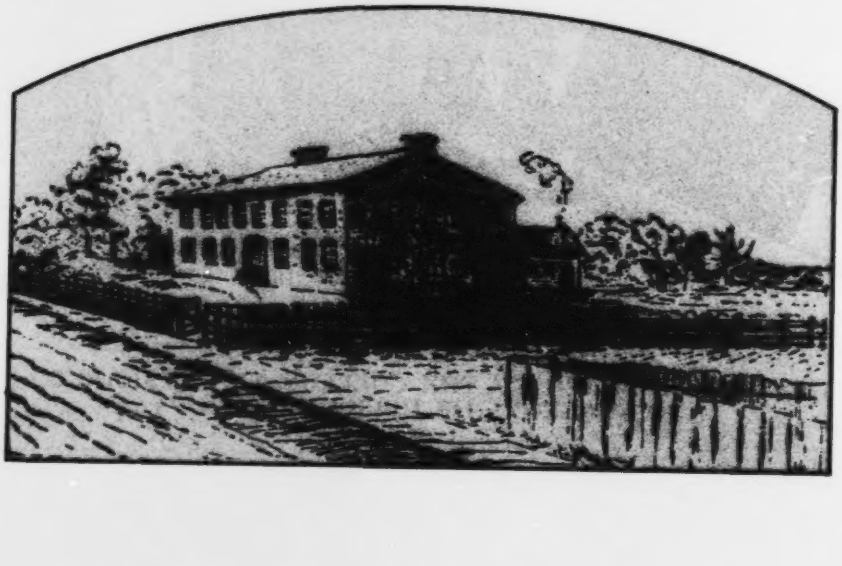
In 1859, the climate and overwork forced Dr. Barry to return to England. The doctor died in 1865, and only then was the deep secret of Dr. James Miranda Barry discovered. She was a woman!

Disguised as a young man, she had enrolled at Edinburgh University in 1809 at the age of 10. By her decision to dedicate her life to medicine, a profession that was not accessible to women in the early 19th Century, Dr. Barry had sacrificed both family life and close friendships.

By the time of her death, Dr. Barry had been joined in the health care field by such devoted women as Florence Nightingale and her nurses of the Crimean Hospitals.

Dr. Barry had not been alone in her concern about sanitation and the purity of drinking water in the mid-1800's. As a result of filthy living conditions and contamination, the colony and much of the western world had been ravaged by cholera.

In 1832, the first major cholera epidemic struck the young colony of Upper Canada. It had been preceded by outbreaks of smallpox and malaria, and, in 1829, by an epidemic of measles that left many children dead. But cholera was virulent and highly infectious, a killer like no other.

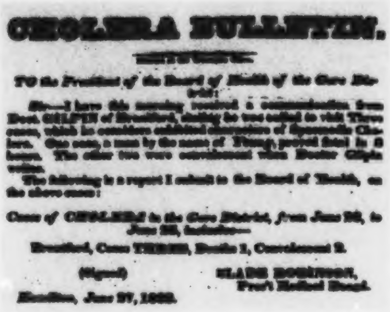


Y General Hospital, which b Toronto General Hos- p 1834, was first lo- c n the north west corner of y and John Streets. F d by the Loyal and P ic Society of Upper C a, the two-storey red b building housed the l ture from 1825 to 1

Victims died within six hours of being infected, according to one writer. A crowd gathered at a circus in London, Ontario, spread the disease into the backwoods; a Hamilton church congregation carried it home from the service; a drunk in a York jail infected all the other inmates.

The epidemic of 1832 caused hundreds of deaths, but very little was known about the disease. It struck with devastating force again in 1837, 1847, 1849, and again in 1854. On August 9, 1854, the Toronto *Examiner* reported 117 deaths in the cholera hospital over a five-week period. In Cornwall, in three days, 31 people died. At Niagara, victims of the disease were dying at the rate of 10 a day. Houses were burned to the ground because it was not possible to enter them to bring out the corpses.

During this period, cholera was considered largely a moral disease, the wages of sin and the product of intemperance. It was in many cases treated by forms of witchcraft or by prayer.



CHOLERA BULLETIN.

During the 1850s, cholera was recognized to be the result of polluted water, poor sanitation, and crowded living conditions; but the disease continued to menace the populations throughout the world well into the next century. At the same time, the ever-present threat of a cholera epidemic acted as one of the greatest spurs to the public health movement. It was directly responsible for the appointment in Ontario of the first "scavengers" or garbage collectors.

During the last half of the 19th Century the medical profession in Ontario experienced normal growing pains. The Churc of England created King's College, denominational school, and its faculty o medicine, in 1843. King's College foun itself rivalled by a reformist institution, th Toronto School of Medicine. Controvers and partisan debate occurred in what wa no more than the very necessary proces of a young profession establishing itsel and setting its standards.

One hundred years ago, medical discoveries were being made daily, but mos doctors were so isolated they might neve hear of them. In 1880, the Ontario Medica Association was founded to end the isolation of many of the 2,100 practitioners i the province and to give them the mean of communicating vital information t each other. Five years later, the OMA boasted a medical library.

THE STUDENT EXAMINED

THE MEDICAL BOARD OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF UPPER CANADA.

A rather abject student is examined by The Medical Board of the College of Physicians and Surgeons of Upper Canada in this cartoon from the 1800s. Dr. Christopher Widmer, one of Ontario's pioneer doctors, is the examiner on the left, giving a sceptical nudge to his glasses.

- By 1880, there were 15 hospitals in the province, and the number would increase to 43 by the turn of the century.
- In 1881, a new medical school was founded at the University of Western Ontario in London, joining the medical schools at Toronto and Kingston.
- In 1882, Dr. Theophilus Mack established the first Canadian school of nursing at the St. Catharines General and Marine Hospital.
- In 1883, two medical schools were established for women.
- In 1885, just outside Palmerston, Dr. Alex Stewart started a vaccine farm to produce vaccine for smallpox inoculations with financial help from the provincial government.

If you had lived in 1882, you would have had an even chance of dying before you reached your fifth birthday. Life expectancy was 36 years. Today, 100 years later, life expectancy has almost doubled.

Public health care has played a major role in our improved life expectancy. The growth and development that have taken place in public health in Ontario over the past century are as vital a part of medical progress in this province as the discovery of insulin or the invention of the "cobalt bomb" for the treatment of cancer.

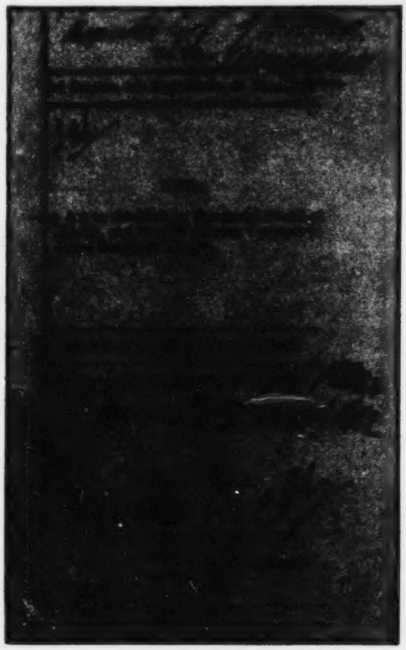
Dr. Theophilus Mack, Founder of the Mack Training School for Nurses, St. Catharines, the first nursing school in Canada

The first medical school in Upper Canada was King's College in Toronto. It opened in 1844.

I — The First Decade — 1882–1892

The health care system enjoyed by Ontarians now was founded on the strength of a statement that rings as true today as when it was made by Dr. Henry I. Bowditch to the International Medical Congress of 1876. It was quoted in the *First Annual Report* of the Provincial Board of Health.

"Theoretically, Public Hygiene is the most important matter any community can discuss, for upon it, in its perfection, depend all the powers, moral, intellectual and physical, of a State."



The Provincial Board of Health was established on March 10, 1882, by an Act of the Legislative Assembly of Ontario. There had been central boards of health before it, set up as temporary, emergency bodies to deal with threatened epidemics and contagion; but the Provincial Board of Health was the first permanent central body intended to "take cognizance of the interests of health and life among the people of the province."

It was specifically charged with distributing information about sanitation, making sanitary inspections, advising local health officials about public health, water supplies, and sewage improvement, maintaining supplies of vaccine which would be provided to doctors at cost, and studying the vital statistics of the province to understand something about the nature and causes of infectious disease. Among the duties of the secretary of the Board was to encourage municipal councils to appoint health officers or local boards of health.

Ontario's municipalities already had the authority, under enabling legislation, to set up their own local boards of health, but they had been slow to act. In 1882 there were only 50 local boards across the province, and 12 counties had no boards at all. Many boards existed only nominally since they had no health officers or sanitary inspectors to enforce any by-laws set by the board. Two years later, legislation made it mandatory for municipal governments to establish local boards of health.

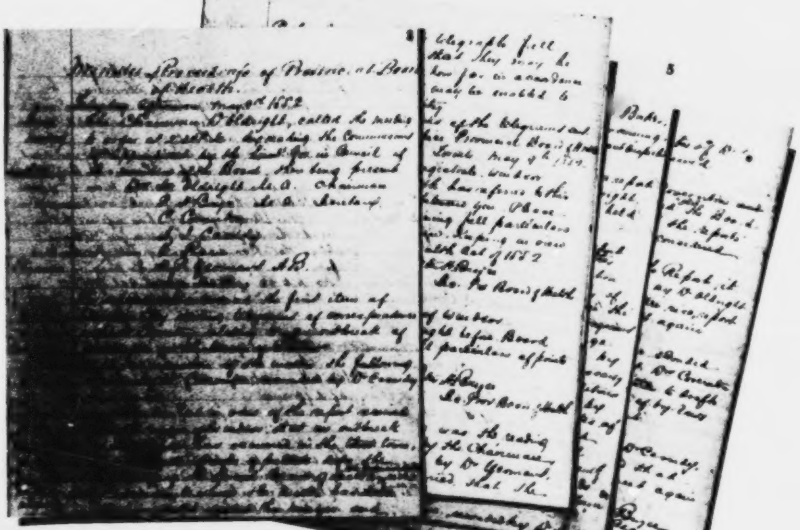
The First Annual Report of the Provincial Board of Health suggested that six or seven people out of every 10,000 in each of Ontario's towns were dying every year because of "ignorance or non-observance of sanitary laws." The Board understood the importance of emphasizing hygiene and sanitation and of educating the public about them. By now it was known that future epidemics could be cultivated from the filth of growing communities.

In Sarnia, for example, the local health investigation commission found that typhoid fever was endemic in the community because the main trunk sewer of the town ran into the bay within 150 feet of the intake pipe for the town's water supply.

Similar sanitary problems existed in most cities and towns in Ontario. Indoor plumbing was a luxury that brought with it the risk of contaminated drinking water. Badly planned and designed sewage systems meant that many houses were actually sitting on top of cesspools, releasing dangerous gases and bacteriological contaminants.

The Board, with its centralized authority was aware of the need for diplomacy in its campaign to prevent and control the spread of infectious disease. During its first year, an outbreak of smallpox in Windsor brought on a near riot involving local health authorities and relatives and friends of the victims who resisted the idea of putting them in quarantine. According to its First Annual Report, the Provincial Board of Health intervened and there followed an "implicit obedience to the Local Health Board, resulting in the speedy stamping out of this disease. . . ."

From its inception, the Board had stressed the importance of gathering and studying regular data to track the movement of epidemics and to investigate the causes of infectious disease. The Board asked all medical people in the province



The minutes of the first meeting, in 1882, of the new Provincial Board of Health, include an account of a smallpox outbreak in the town of Windsor.

to make monthly reports to it; maps displaying the frequency of various infectious diseases in each district were distributed publicly through a "*Health Bulletin*". Health information was gathered not only from the 10 health districts in Ontario, but also from many sources throughout the world, and used in appeals to the public to improve sanitation, achieve better co-operation in inoculation programs and encourage the use of quarantine.

In 1883, the Board was compiling weekly reports on prevalent diseases: smallpox, measles, diphtheria, scarlet fever, and malaria and many others little remembered today. In the same year, a major sanitary convention was held in London, Ontario, furthering the cause of educating the public in the need for improved sanitation on all fronts.

That July, when the worst flood in the recorded history of the province inundated the suburbs of London, the citizens and local authorities pitched in to clean up the filth and debris. The clean-up operation was credited with saving more lives than the flood itself had taken.

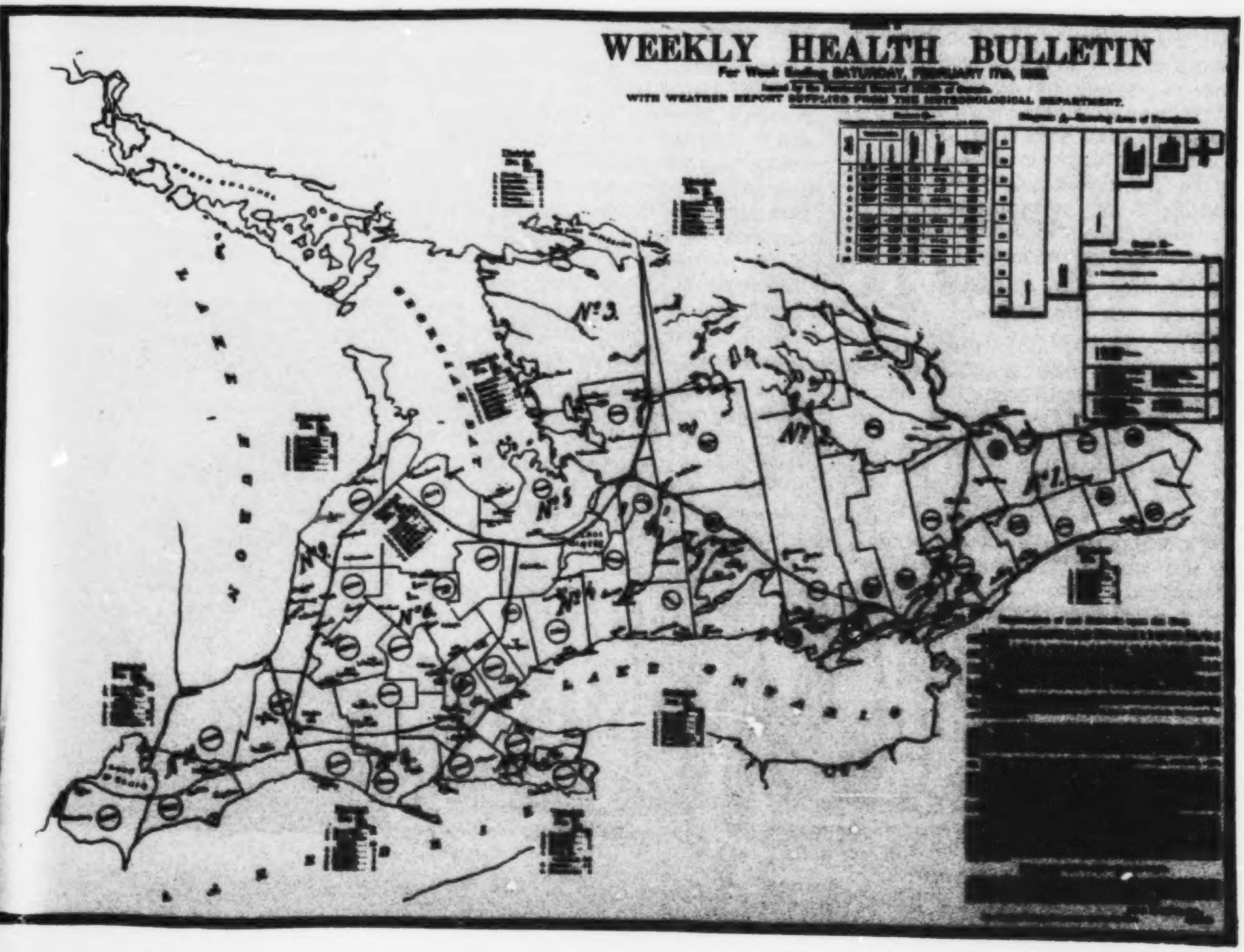
It was clear that the public was beginning to respond to the efforts of the Board, though some communities set about promoting and overseeing public health with more energy and imagination than others. For example, the town of Hamilton, whose death toll from infectious disease was relatively low, had initiated one of the first municipal garbage collection systems. In 1884, it ran a two-month trial of a "scavenger system" using two single wagons to pick up tons of garbage and ashes at a cost of two dollars a day. The trial was a success, and larger wagons served the whole town with regular refuse collection.

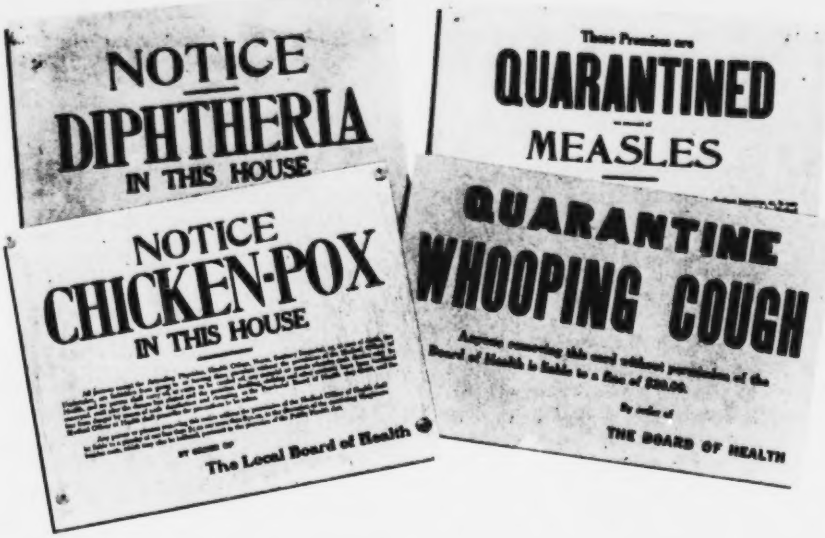
The most effective piece of legislation passed in the first half-century of health care in Ontario was the Public Health Act of 1884. Public health at the local level was no longer a question of choice. Now local governments were compelled by law to set up health boards and impose health and sanitary regulations on their communities.

The bill integrated all existing legislation governing public health and incorporated the previous Act of 1882 under which the Board had been formed. It was the first truly comprehensive health guide in the new province.

Dr. Peter H. Bryce, then secretary of the Provincial Board of Health, was responsible for persuading local councils to create boards of health. He was rightly given full credit for the Bill.

There was, however, continued resistance in many communities to the idea of setting up local boards. Some municipalities insisted they had such exemplary sanitary conditions that they could see no need to set up a local board. But the folly of continued resistance was brought home by a devastating outbreak of smallpox in one of the municipalities that had refused to comply with the new law. In Hungerford Township, Hastings County,





NOTICE
DIPHTHERIA
IN THIS HOUSE

NOTICE
CHICKEN-POX
IN THIS HOUSE

The Local Board of Health

These Premises are
QUARANTINED
MEASLES

QUARANTINE
WHOOPING COUGH

Anyone removing this card without permission of the Board of Health is liable to a fine of $20.00.

By order of
THE BOARD OF HEALTH

Quarantine notices posted by local boards of health on citizens' houses carried warnings of fines for removal without permission.

smallpox spread rapidly. The provincial board was forced to step in, and through vaccinations, re-vaccinations, enforced quarantine and inspections, the disease was finally put down after a needless loss of many lives. Most communities, however, did obey the new law. Four hundred boards of health were formed during the first year, representing nearly two-thirds of all the municipalities in the province. Unfortunately, as Dr. Bryce noted, only a fraction had any staff or medical officers of health. There were only 65 with MOHs and 96 with sanitary inspectors. Dr. Bryce chided the communities for thinking more about money than about lives.

Public health also meant keeping disease out of Ontario.

On November 12, 1885, a man travelling by train from Montreal got off at Hull and crossed the provincial border into Ontario under cover of darkness. In Ottawa, he was spotted by a doctor who immediately had him arrested, taken to jail, and vaccinated against smallpox. The man had violated a new and strictly enforced law in Ontario, the Smallpox Regulation of 1885. He was only one of many travellers from Quebec who were rounded up, fumigated, and vaccinated as part of a drive by the Provincial Board of Health to stop the spread of the smallpox epidemic of 1885 in Ontario.

During the last half of the year, smallpox had killed 7,000 people in Quebec. To prevent a similar toll in Ontario, the provincial government passed the Smallpox Regulation. It was designed to seal off the province from people carrying the disease from Quebec.

Armed with the September Order-In-Council, the Provincial Board acted promptly. A medical staff was appointed and its chief sent to Montreal to set up a sanitary cordon. Members of the staff boarded trains bound for Ontario, inspecting passengers and live freight for symptoms of smallpox or for those requiring vaccination. These health officials had the power to arrest, upon entry into Ontario, anyone who refused to be vaccinated or could not prove that he had been recently and successfully vaccinated.

This plan of keeping people out instead of shutting them in — a reverse quarantine — was effective. By the year's end, there were only 146 cases of smallpox reported in Ontario and, of those, only 42 were considered to have been "imported". Only 10 people died.

Throughout 1885 and the following years, there was steady progress in the formation of local health boards. By 188 , with 610 municipalities reporting to the central Board, virtually the entire province was represented. Dr. Bryce was now the permanent secretary of the Provincial Board and spearheaded various pieces of legislation that would become lasting features of Ontario's public health system.

In 1885, the Vaccination Act was amended, and a general system of vaccination was introduced. Trustees might now require children to show certificates as proof of successful vaccination before they were admitted to school.

In 1886, as a result of a Board's quarantine report about smallpox among some Russian emigrants travelling up the St. Lawrence River, an Order-In-Council was passed to check the introduction of contagious disease by boat-passengers.

In 1887, legislation was passed to control disease in animals. Tuberculosis was frequently found in milk cows and other cattle. There were local outbreaks of anthrax and hog-cholera. Medical officers of health were given the power to prosecute any person who had an animal suffering from any of these diseases.

Dr. Peter H. Bryce, First Secretary of the Provincial Board of Health, 1882–1904

One of the major medical events of the first decade of the Provincial Board of Health was the establishment in Toronto of the provincial bacteriological laboratory in 1890.

Opened under the direction of Professor J.J. MacKenzie as a laboratory for chemical analysis and diagnostic work, it was probably the first public health laboratory in North America. During its early years, it confirmed diphtheria, tuberculosis and typhoid fever through laboratory analysis of throat cultures and specimens of sputum and blood.

During its first 10 years, the Provincial Board of Health's principal concern was educating the public about the importance of vaccination, quarantine, and proper sanitation in the control of infectious disease. The Board was later to inspect and demand changes in water systems throughout the province, and it was empowered to approve all proposed systems of sewage treatment in Ontario.

Professor J.J. MacKenzie, Director of the Board's first Public Health Laboratory, which opened in Toronto in 1890

Local boards, an important link between central authority and the individual citizen, took up their responsibilities as overseers of local conditions and enforcers of public health laws.

The first decade of the Provincial Board of Health was spent in building the infrastructure for, and awareness of, public health, in this vigorous but still pioneering province. As the Board stressed in its annual reports, we couldn't afford to waste lives through diseases that could be prevented.

II — The Second Decade — 1892–1902

If any single concern predominated during the second decade of Ontario's public health system, it was the drive against tuberculosis. This disease was the number-one killer in the province throughout most of the 19th Century.

The tubercule bacillus responsible for TB had been identified in 1882, but it would be three generations before the disease known as consumption would be all but eradicated on the North American continent.

The activities of the new bacteriological laboratory, set up by the Provincial Board of Health in 1890, were crucial in tracking down the cause of tuberculosis in both man and animals.

It was known that overcrowding and climate were important factors in the spread and persistence of TB, and the presence of tuberculosis in animals led to a call for cattle inspections. Legislation in 1896 and 1900 gave the Board more control over licensing and inspecting of meat and milk supplies, but progress was slow.

That same year, the Toronto death returns to the provincial Board listed 291 people who had died of consumption during the year. Of those, 184 were between 15 and 60 years of age, and, of those, 52 were listed as "housewives." In many cases, TB carried off hardy souls who had survived other lethal infectious diseases such as typhoid fever.

Women tuberculosis patients sit on the porch of the Toronto Hospital for Consumptives in 1905. This is now the West Park Hospital.

Dr. Bryce spoke of the women who had died of TB when he addressed the National Council of Women in Ottawa in May, 1898:

"To none of us is there in the misfortunes of life any occurrence which seems sadder or which appeals more to human sympathy than the loss to children of a mother's care.

"Sadder still is the thought that extending this to them to the last moment of her life she in many instances has become the innocent medium of communicating the seeds of this fatal disease before she has left them."

Ontario's first sanatorium for the isolation and treatment of tubercular patients was opened the year before at Gravenhurst in the Muskoka area. In his speech to women in Ottawa, Dr. Bryce grimly predicted that in the next 15 years many more TB hospitals would be needed.

The Muskoka Cottage Sanatorium for tuberculosis patients was built in 1897.

Dr. Bryce had seen the number of hospitals that were receiving aid from the provincial government rise from 10 in 1878, to 47 in 1898. The number of patients had risen five-fold in that period, and these hospitals did not include the temporary facilities that were constructed as isolation wards for contagious diseases. Most hospitals existed to look after charity cases. Yet the Charity Act forbade the placement of patients with infectious diseases in general hospital buildings.

A combination of greater awareness of public health, hospital care, medical advances and an increase in medical personnel paid off in Ontario. From 1882 to 1886, the first five years of the provincial Board's existence, there had been 128 deaths from smallpox in the province. During the corresponding period of the second decade, there were only seven deaths from smallpox.

Deaths from scarlatina meanwhile were reduced by half; from typhoid by more than half, but deaths from diphtheria were down by only six per cent.

During the Board's second decade, attention was focussed on another area of public health. Tooth decay, particularly among children, had become the concern of the Toronto Trades and Labour Council and the Toronto Dental Society. Dentists representing these groups had examined the teeth of many children and found them to be in extremely bad condition.

One Toronto dentist estimated that 50 per cent of the public school children in Canada had rotten teeth as a result of eating soft foods and too much candy. He said that for every person in Canada with sound teeth, there were 10 in England. He concluded that nearly all Canadians had bad teeth because of their almost total lack of dental hygiene and poor eating habits.

During the years spanning 1892–1901, the Board extended its mandate over public health. It surveyed sanitary conditions aboard the passenger trains in the province. The Board was given the power to approve or reject all proposed systems of sewage treatment and disposal and of water supplies in the municipalities. Just after the turn of the century, the Board began to test the quality of lake water in the Muskoka and Kawartha Lake tourist areas. It gradually took over the maintenance of water quality in all lake systems.

III — The Third Decade — 1902–1912

In the fall of 1906, Dr. R.W. Bell, Medical Inspector for the Provincial Board of Health, paid visits to 68 canning factories in the Niagara region. He discovered that 6,000 people, most of them women, were employed by these canneries, with one half of the workers imported from Buffalo. They joined several hundred Indians brought from Brantford and Caledonia.

The doctor found conditions in the housing provided by the cannery operators far below the standards specified by the Public Health Act. Most of the migratory workers were crowded into shacks with only one stove and straw mattresses on the floor. Thirty or 40 people were sometimes crammed into one apartment, with families separated by rough board partitions. There were few tables, and women and children sat on the floor or on the sides of their beds to eat their food.

The dwellings of the workers were never swept or scrubbed. Up to 20 people would share one tin wash basin. Dishes went unwashed. Food was stored in dirty fruit baskets under the beds, and waste food lay on beds swarming with flies. Lighting was poor and ventilation inadequate.

In the factories themselves, workers stood on wet floors covered with slop. A notice in one factory visited by Dr. Bell reminded the workers to wash their hands after using "the bathroom closet"; but there was only a small iron sink for wash-ups. There were no towels or soap. Where towels were supplied, they were so filthy the workers preferred to dry their hands on their dirty aprons.

"Yet," wrote Dr. Bell, "these are the persons who are employed to handle and put up our choicest foods." In his report, the doctor noted that employees could not be expected to be cleaner than their surroundings. "Where cleanliness about the premises is sacrificed in order to turn out quantity, then quantity must be of secondary consideration." He recommended enforcement of the Factory Acts and suggested further legislation.

Dr. Charles A. Hodgetts, who had been the first medical inspector of the province, was now permanent secretary of the provincial Board. Under Dr. Hodgetts, the Board's inspectors launched campaigns against unsanitary conditions in the canning industry and in a variety of other business enterprises. As the tempo of sanitation reform picked up, the Board's work became increasingly controversial. The canning industry complained that the Board was giving it a bad name. But the Board found supporters, not only among municipal governments, but among volunteer groups.

The reports on conditions in the canning industry brought about a war of "scoops" in the press. Several newspapers sent reporters to the factories, and some papers took the industry's view that the public health staff had overreacted. However, there were those within the canning industry who felt the publicity had been what was needed to wake people up and "remedy many undesirable conditions. . .overlooked in the past".

A year later, Dr. Bell was able to report with much satisfaction that "the dirtiest and most unsanitary factory has gone out of business. . .and several others have very much improved". At least two factories had built two-storey buildings for their employees with well lighted and ventilated rooms, baths and wash basins.

During its third decade, the Board reported its progress in improving other working conditions in the province. Most lumber camps were meeting the provincial requirement that they hire a doctor to examine the loggers regularly. The railways were killing the vermin that had infested their passenger cars by fumigating with formaldehyde gas. Barber shops across the province were being instructed to clean up their establishments.

But there was much yet to be done. Tuberculosis was still considered to be the worst disease by the provincial Board. In 1911, a medical inspector investigated a condemned carcass at a large abattoir in Toronto. He reported a heifer "practically lined with tuberculosis from stem to stern". The inspector said that federal meat inspectors admitted to him that infected meat, turned down by city dealers, would be sold to local butchers in small towns and villages. The provincial inspector noted, "If we are to have any results in the prevention of tuberculosis and other diseases, we must have some system of rigid inspection of all meat used by our citizens."

Dr. Charles A. Hodgetts, first medical inspector of the province and Secretary of the Provincial Board of Health from 1904 to 1910.

A Provincial Board of Health display at the 1912 CNE demonstrates sanitary measures that will prevent the spread of tuberculosis, considered by the Board to be the worst contagious disease of that time.

PURE AIR
DAY & NIGHT
PREVENT
NEW
SANITARY
OLD

In one of the first attempts on the North American continent to enlist all-out public support for a health program, the Provincial Board mounted its Tuberculosis Exhibit and sent it out to tour Ontario and parts of Quebec between 1908 and 1910. In 1909, the exhibit was the first in Canada to be installed in a railway car and sent on a provincial tour.

The exhibit demonstrated the prevalence of the disease with maps and charts; it showed the ways in which it was spread, how it could be prevented, and how it was cured. Photographs, colored pictures, models of tents and sanatoria buildings, and doctor's lectures enlivened by lantern slides were part of the exhibit. Two hundred and fifty thousand pamphlets describing the causes and treatment of the disease, which was also known as the great white plague, were distributed. The exhibit was seen by thousands of Ontario residents and, during a two-week visit to Montreal in 1908, 60,000 people were reported to have seen the exhibit.

The International Order of the Daughters of the Empire spearheaded a drive to raise funds for a sanatorium that was built in St. Catharines in 1909.

This kind of public education was bound to bring responses. The Daughters of the Empire held a fund-raising drive to build a sanatorium in St. Catharines. Ten thousand dollars in public subscriptions was raised, enough to pay the entire cost of the building. The sanatorium was opened in 1909 by the Provincial Secretary for Health, W.J. Hanna.

While the Board had a great deal of support from the public and from other levels of government for its battles against the common infectious diseases of the day, it also faced outbursts of opposition. By 1906, an anti-vaccination movement had become very strong. Members of the movement were labelled "metaphysicians, religious fanatics and faddists" by Dr. Hodgetts. Their objections to compulsory vaccination were on the grounds that compulsion was contrary to free will and the liberty of the individual. The Board's supporters pointed out that personal liberty and free will have legal limits and cannot be allowed to conflict with the common good.

Occasionally, some towns would not follow public health guidelines because they had theories of their own. In 1909, the Town of Lindsay installed an ozone purification plant against the advice of the Board's experts. The plant failed to purify the town's water, causing the Board to lament the large amount of money the town had wasted.

The third decade saw an amendment to the Public Health Act in 1903, permitting medical officers of health to enter and inspect tenements, lodging houses and laundries and to take action if they were overcrowded or filthy. In the same year, the Board's committee on school hygiene investigated sanitary conditions in the schools and experimented with ventilation to find the most effective system. In the following year, the first branch of the Board's bacteriological laboratory was opened at Queen's University at Kingston, under the direction of Dr. W.D. Connell.

The work of the central laboratory at Toronto was continuing meanwhile in imaginative ways. Dr. John A. Amyot, the bacteriologist in charge of the laboratory, initiated testing and analysis of various consumer items. He studied patent medicines, beef extracts and various other foods. Tests showed surprisingly large amounts of alcohol present in patent medicines, but far less adulteration in common foods than had been expected.

Of numerous other developments during the third decade, some had far-reaching significance. In 1905, the University of Toronto established a degree course in public health medicine, thus ensuring a continuous supply of health officers. The Provincial Board entered into negotiations with local Quebec boards of health to try to reach an agreement on the disposal of raw sewage into the Ottawa River.

The rabies outbreak in Western Ontario in 1910 offered a vivid illustration of how far the Board had come since the days when it had engaged in fierce debate with municipalities over the need for local boards of health. Acting on a proclamation issued by Ottawa, the Board issued regulations which charged municipal authorities and provincial police west of York and Simcoe with enforcing an order that all dogs be muzzled or chained. A directive was issued outlining procedures for dealing with rabid animals. Rabies vaccine was ordered by the Board from the Research Laboratory of the City of New York at a cost of $25 per patient, a sum which, though high, still represented a considerable saving over having to send patients to New York to receive the vaccine.

Dr. John A. Amyot, in charge of the central Public Health Laboratory in Toronto, initiated the testing of various consumer items.

Seventy-three people were treated with rabies vaccine at Toronto General Hospital and at the Hospital for Sick Children. All survived.

As in all endeavors, progress for the Board sometimes involved one step back for every two steps forward. In 1911, 14 people died in an outbreak of typhoid fever in Sarnia. This was especially disturbing because the need for an uncontaminated water supply in the town had been pointed out by a Board study more than 30 years earlier.

On the other hand, it was the growing awareness of the need for public health that was behind sanitary measures being adopted by the operators of many mines in Northern Ontario. A cheap form of portable privy was installed at two mines, and the miners were being provided with drinking water underground.

There were changes within the Board itself during the third decade. The Annual Report was replaced with regular editions of *The Sanitary Journal*. In 1910, the Board's second permanent secretary, Dr. Charles A. Hodgetts, resigned to take another position. He was replaced by Dr. John W.S. McCullough who, near the end of the decade, wrote of "the increased interest being taken by the public in the prevention of disease, evidenced by the medical inspection of schools, lectures and housing, town planning and the prevention of slums and regulation of apartment houses. . . .It may be called a healthy sign when the man in the street shows his appreciation of these matters."

IV — The Fourth Decade — 1912–1922

In 1921, the last year of the fourth decade, Dr. John W.S. McCullough, the Board's third permanent secretary and the province's Chief Medical Officer of Health, was able to look back on the preceding ten years and acknowledge a string of impressive successes. Many battles were won but he also foresaw how much remained to be done in building a truly comprehensive public health care system in Ontario.

The network of public health laboratories was growing. The central laboratory at Toronto and its first branch at Kingston were joined by laboratories at London, Fort William, Sault Ste. Marie and North Bay. The Experimental Station at Stanley Park, Toronto, opened in 1908, had expanded, experimenting in the ever-important areas of water purification and sewage disposal.

As a patriotic act, the Toronto Public Health Laboratory on Yonge Street had prepared and supplied free of charge to the Department of Militia and Defense most of the T.A.B. vaccine used by Canadian troops in World War I. The Board calculated that this vaccine, which offered protection against intestinal diseases, would have cost the federal government $1.25 million. The vaccine saved thousands of lives which in other wars would have been taken by typhoid fever.

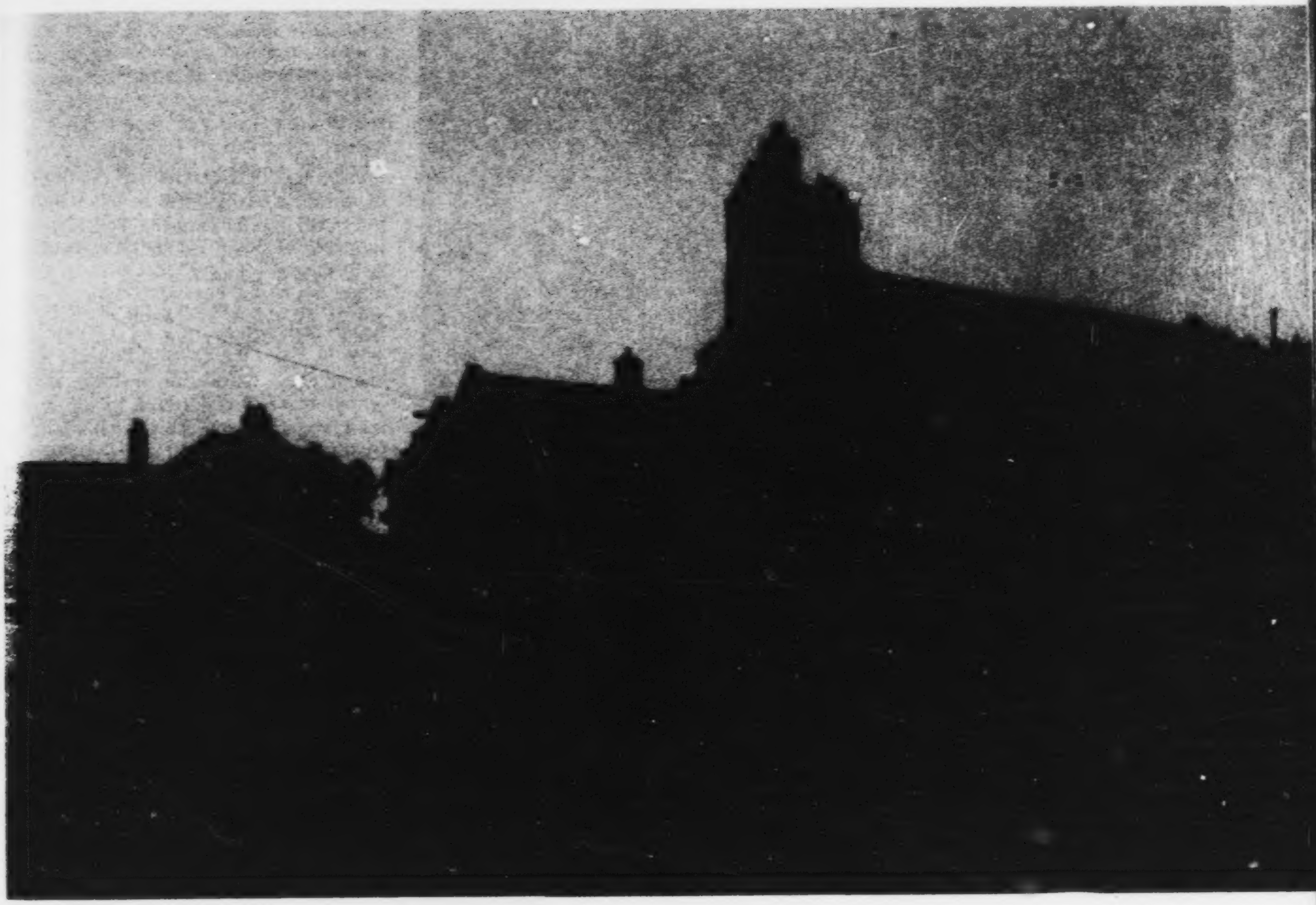
While examining about 1,000 specimens a week, the laboratory at Toronto also prepared whooping cough vaccine and provided the Pasteur preventive treatment for rabies. It produced the ointment used in the treatment of venereal disease; this ointment was distributed free in the Board's V.D. Clinics under the Venereal Diseases Prevention Act of 1918.

Canadian Troops in World War I were supplied free vaccine against intestinal diseases by the Public Health Laboratory in Toronto.

A public drug program was pioneered by the Board in 1914. With the co-operation of Sir Edmund Osler, then Chairman of the Medical Section of the Commission of Conservation and a Governor of the University of Toronto, the Board obtained a supply of vaccines and antitoxins from the university lab at a cost far lower than that charged commercially. It was quite an improvement over what had existed during the rabies outbreak in 1910, when vaccine had to be imported from New York at a cost of $25 a patient.

In 1916, Col. Albert E. Gooderham donated a 51-acre farm to the University of Toronto for its antitoxin work. The farm was named Connaught Laboratories, and all vaccines and antitoxins produced there were given out by the provincial board to the public at no charge. This was an important step in the drive to control preventable infectious disease. Soon, all laboratories, within the provincial Board's jurisdiction, were supplying vaccines and antitoxins, with excellent results. In 1908, there were 31 deaths for every 100,000 people from diphtheria; in 1918, this figure had dropped to 12.

The Public Health Laboratory in Toronto examined about 1,000 specimens a week during the early 1920s.



The original site of the University of Toronto's Connaught Laboratories was a 51-acre farm donated to the university by Col. Albert E. Gooderham in 1916.

Mass vaccinations carried out regularly against such diseases as smallpox and whooping cough were instrumental in saving countless lives.

From the start of the fourth decade, there were numerous legislative changes that reflected the Board's response to the growing complexities of public health care needs. As a result of the revision of the Public Health Act in 1912, full-time district health officers were appointed to take charge of the province's 10 health districts. Public health laws which had been scattered throughout various pieces of legislation benefited by consolidation under the revised Act. Annual conferences for local medical officers of health were also established under the revised legislation. Local medical officers in Ontario have met every year since 1912.

Later in the decade, the provincial Board of Health was transferred from the Department of the Provincial Secretary to the Department of Labour; and in the following year, 1920, the Board adopted a divisional form of administration, a move that corresponded with its increasing responsibilities. Some of the designated divisions were not new: Sanitary Engineering, Laboratories, Venereal Diseases and Epidemiology had existed in former administrative structures. Some were new: the Division of Maternal and Child Welfare and Public Health Nursing, the Division of Public Health Education, and the Division of Industrial Hygiene were innovative in the world of public health. The Division of Industrial Hygiene, certainly, was the first of its kind in Canada.

There was a pressing need for public health action in all areas of the new division. In 1905, the Ontario Medical Association had called for a ban on the employment of children in factories and for a program of medical examinations for school children. Much had been done to curb the abuse and neglect of children's health, but a systematic approach was needed. The formation of the new Division of Maternal and Child Welfare and Public Health Nursing promised changes.

The new division, the actual beginning of the public health nursing system as it is known today, was established with the indispensable help of the Canadian Red Cross Society. The Society supplied eight nurses to the province and maintained them for a period of 15 months between 1920 and 1921. This generosity enabled the Board to staff the 10 health districts with two nurses each instead of one. Outside help of this kind was badly needed by the Board at a time when local municipalities were not able or simply refused to finance public health nurses.

Two public health nurses photographed on a railway hand-car in Northern Ontario in 1921

The division saw its most important ork in an extensive health education ogram that stressed maternal and child giene. Educational health campaigns d always been a crucial part of the ard's work, and for 10 years it had onsored an annual exhibit at the Cana- in National Exhibition in Toronto. In 21, the theme of the exhibit was child alth; but rather than a gloomy lesson out sickness and death, the children ere treated to a stage set with colorful tdoor scenery where Happy the Health own cavorted and a small child named ive Russell recited health jingles. Like e TB exhibit before it, this exhibit toured e province by train.

As there had been no previous attempts put public health nurses in the field, ere was naturally no program designed train them. In response to this lack, the oard devised a program of its own which ained prospective public health nurses or the thousands of visits they would make each year to homes, schools, and clinics.

Happy the Health Clown made learning about nutrition and health fun for young children in 1921.

The work of the public health nurses was immediately successful. At the Burnside Lying-in Hospital at Toronto, the division ran a pre-natal clinic. In unsupervised public-ward cases, infant mortality was 35 per 1,000 births. In the public-ward cases supervised by the division's public health nurses, infant mortality was four per 1,000. The nurses' supervision also had a bearing on the number of stillbirths: 79 in the public, unsupervised wards; only 13 in public wards supervised by the division's nurses. The case for medical supervision of pregnant women had been made, and the importance of preventive medicine illustrated.

Unfortunately, not even a battalion of public health nurses could have much effect on many of the infectious diseases that were common among children. Polio left countless children and adults crippled. The doctors on the provincial Board were deeply concerned by the way infectious diseases — diphtheria, measles, whooping cough and scarlet fever — were dismissed. Many parents put down their children's ills to growing pains, and some even thought it advisable to let their children contract such diseases, ignorant of the dangerous after effects.

Besides the established infectious diseases the newly formed Division of Public Health Education had to deal with, there were the less known but equally alarming diseases becoming more prevalent, such as cancer. The Board estimated that cancer was killing about 7,000 people a year in Canada by 1920; in people over 40 years old, it was killing one in eight women and one in 14 men.

Almost nothing was known about cancer. It was recognized as a disease primarily of adulthood, considered curable when discovered in its very earliest stages, and

A Provincial Board of Health Baby Clinic Exhibition in 1918, promoting child health and welfare

At the Burnside Lying-in Hospital in Toronto, public health nurses conducted a successful prenatal clinic that dramatically reduced infant mortality.

hopeless once it had established itself. Emphasizing the importance of early detection, the Board publicized some of the danger signs, including any lump or thickening in a woman's breast or any persistent sore on the tongue of a man 45 years old. It advised the removal of warts, moles or skin growths that might be irritated by clothing and reminded people to avoid irritating the tongue and cheeks with jagged teeth or clay pipes.

While the cancer rate was rising, however, the figures for tuberculosis were falling; and this was in large measure the result of the effort of the provincial Board and the municipal councils.

By the end of the Board's fourth decade, the number of TB sanatoria in Ontario had increased from 10 to 25, or from 615 to 2,000 beds. Mortality rates had been dropping consistently. The Ontario Government was providing generous grants of up to $4,000 for each new sanatorium and 75 cents a day for the care of each patient. It amounted to more than $125,000 a year, and the province felt the federal government should take over a greater share of the financial burden. Except for a $10,000 federal grant, the whole cost of fighting TB was left up to the provinces.

The Board responded to rising cancer statistics with educational pamphlets that identified three danger signals.

The influenza epidemic of 1918–1920 devastated the world. The virulent disease spread from Europe to this continent and killed 10,000 people, taking its greatest toll among young adults. More people died of influenza than had been killed in the First World War.

Although it struck in Ontario every bit as hard as elsewhere, there is some reason to believe that the intensity of the epidemic was lessened by the continuing educational drive by the Board in such areas as overcrowding, sanitation, and proper diet. From 1919 to 1920, the fall in the death rate reflected this belief.

The Division of Industrial Hygiene was a watch dog in the prevention of accidents and occupational disease among miners. Here miners are shown beginning work on a mine shaft at Creighton in 1915.

The close ties enjoyed today between the government's public health care system and volunteer groups were formed during the early years of this century. The Division of Public Health Education and the bodies that preceded it within the Board were able to distribute thousands of pieces of educational material through women's institutes, public schools and volunteer agencies. The division's displays and movies on the prevention of contagious disease and proper nutrition were shown to service clubs and volunteer organizations all over the province. Weekly columns in the press contributed to the effort.

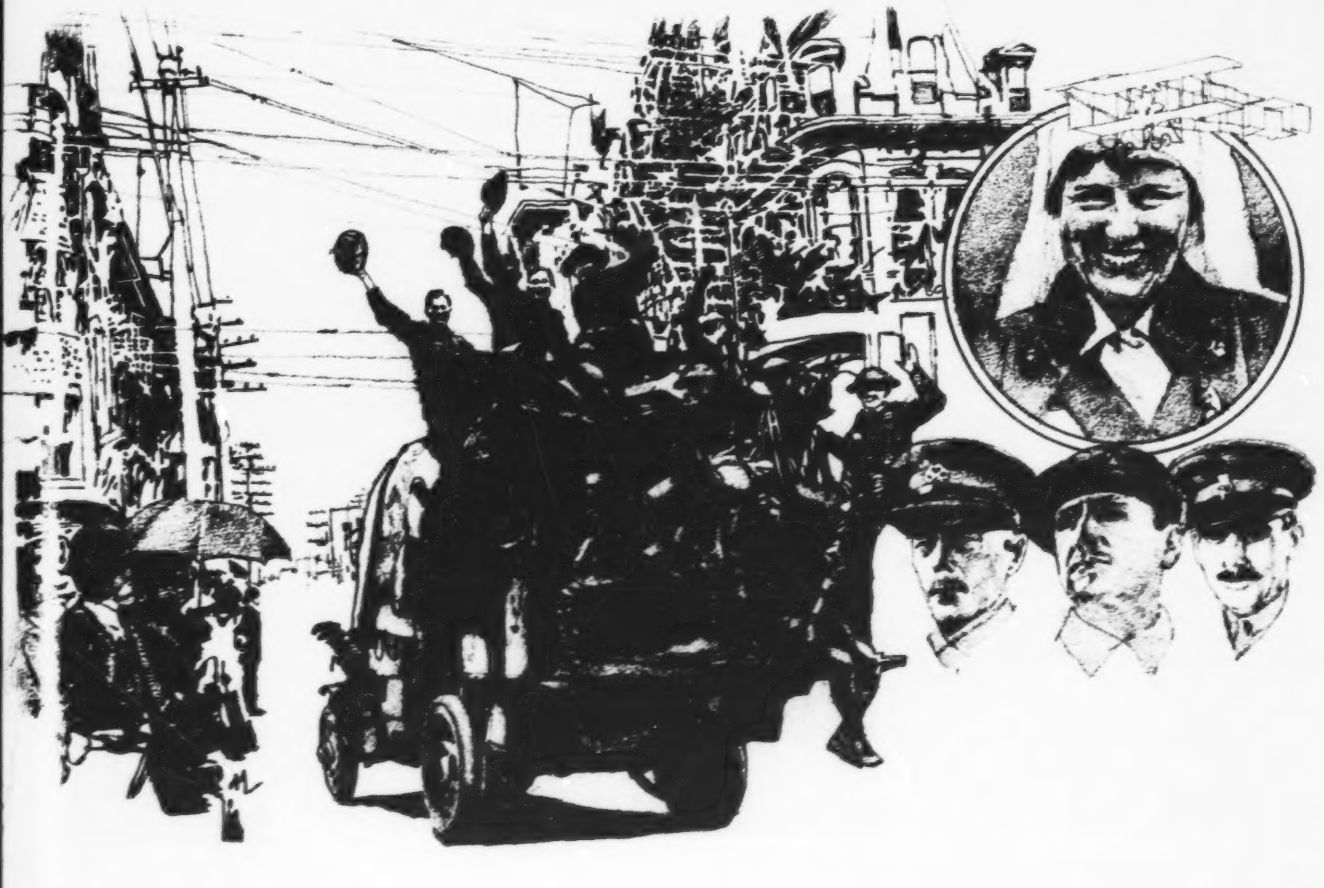
The Division of Industrial Hygiene emphasized prevention. Its work was carried out in an atmosphere of active co-operation between employers and employees rather than one of confrontation. A number of important studies were initiated into the causes of several occupational diseases.

As a result of findings in the hard rock mines of Northern Ontario, mine owners agreed to replace dry drills with wet drills to cut down dust and reduce the incidence of lung disease among miners. Lead poisoning among 110 painters was also studied.

An interesting six-month study made in a small Ontario town explored the possibility of industry financing medical care in the workplace. The necessary health staff was to be provided by industry alone or in co-operation with the municipality. While the results of the study were positive, it was thought there was little room yet for such "advanced" projects when other, fundamental conditions in industry needed urgent attention.

These studies, however, were imaginatively conceived and realistically applied; they led to workable and effective measures to guard health and safety at work.

Historians agree that the 19th century came to a close with the Great War. Perhaps it is also possible to see the start of the 20th century in the work of the Board during the fourth decade. There is no question that the changes were marks of growth and development in response to a changing and increasingly complex society.



V — The Fifth Decade — 1922–1932

The years that lay between the Charleston and the Depression marked a period of increasing professionalism and scientific application in Ontario's public health system.

During the early years of the 20s decade, several important legislative amendments were made in the treatment and control of VD. Free clinics and drugs were already available, and in 1922, the Venereal Diseases Prevention Act was amended to protect the identity of any person even suspected to be suffering from a venereal disease. Cases would be identified without disclosure of names and every local health board was bound to maintain secrecy as far as possible.

An amendment to the Public Health Act empowered municipal councils to appoint additional medical staff where needed to carry out the provisions of the Act in the prevention and treatment of disease. The Provincial Board was awarding substantial grants to municipalities to help them set up their own VD clinics. An education campaign was conducted by doctors and nurses in the public health service in co-operation with the Ontario Social Hygiene Council.

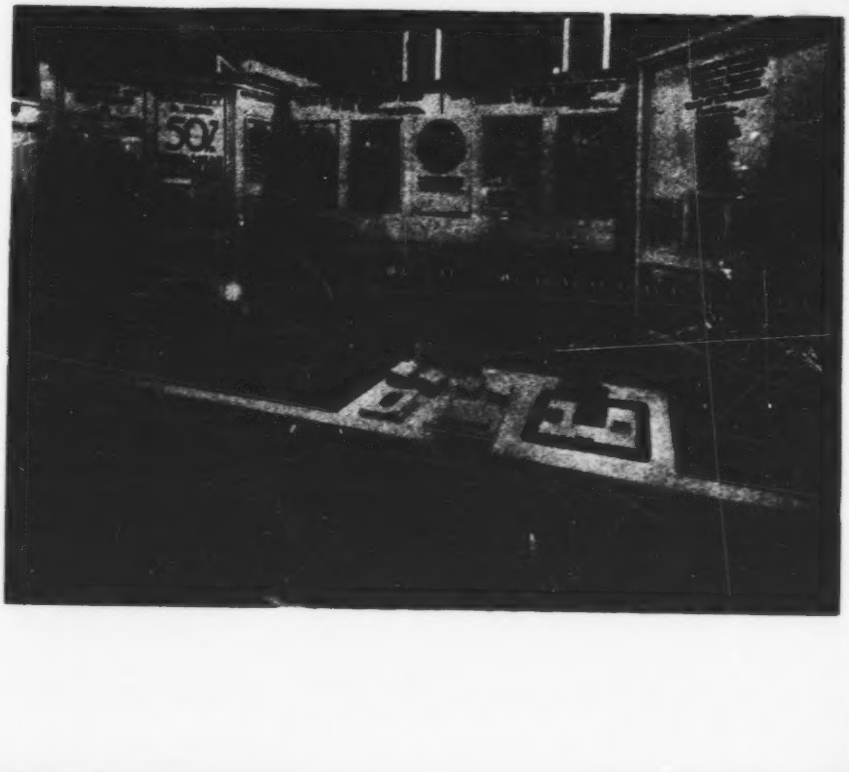
While the idea of using clinics was still new, the value of the VD clinics and the confidentiality of treatment could not be doubted. In the province's 15 clinics, more than 33,000 men and 26,000 women out-patients were treated in 1922, representing an increase of 18,000 treatments over the previous year.

More than 27,000 treatments were also given to in-patients and offered through the clinics to jails and prisons.

The Division of Industrial Hygiene studied occupational diseases and their relation to toxic substances.

Unfortunately, in spite of the obvious success of the VD clinics, the Board could not induce the tuberculosis sanatoria to establish neighborhood clinics for TB. The Board rightly felt that much greater efforts had to be made to catch the disease in its early stages.

Meanwhile, the real veteran of public health service, the Division of Sanitary Engineering, was continuing its vital work in improving water purification systems and sewage disposal. In 1922, the division received applications for 419 water supply and sewage disposal systems worth more



During the early 1920s, the Board sponsored VD displays in an effort to reach all infected persons. The VD Prevention Act, which already provided free clinics and drugs, was amended in 1922 to ensure patient confidentiality.

than $10 million. There had been only eight water purification plants and one chlorination plant in Ontario in 1910. Eleven years later, 42 per cent of the water supplies in Ontario was protected by filtration and more than 82 per cent protected by chlorination. The typhoid death rate reflected the improved water treatment systems. By 1928, toward the end of the Board's fifth decade, more than per cent of all water used for domestic purposes was chlorinated.

The scientific approach the Board was taking was most evident in the work of the Division of Industrial Hygiene. The division investigated 10 different types of occupational disease, completed its report on lead poisoning among painters, decorators and paint manufacturers, and had studied the commercial effects of volatile substances such as benzol, benzine and turpentine. It had been far-sighted enough to recommend additional training in toxicology for medical students. The division alerted practising physicians to the importance of possible occupational factors in their diagnoses.

The Ontario Medical Association, in 1923, also sent a letter to all Ontario physicians defining the extent of industrial disease and requesting reports of all such cases.

In the same year, at the Canadian National Exhibition, this division sponsored the provincial Board's annual health exhibit with a display on the lethal dangers of exposure to industrial poisons. Bulletins were sent to workmen through the YMCA, drawing attention to industrial health, and the Board produced articles on the subject published in trade journals.

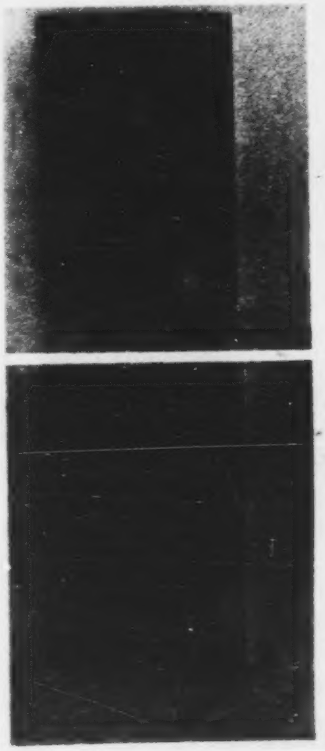
During the Board's fifth decade, legislation — including regulations of the provincial Board itself — began to spell out precise ways of dealing with a long list of infectious diseases. In 1923, 31 regulations went into effect defining procedure for the quarantine, reporting and treatment of sufferers of communicable diseases that included smallpox, diphtheria, chickenpox and rabies.

A quarantine card was to be posted on any building in which there were people with communicable disease. Removal of the card was punishable by a $500 fine.

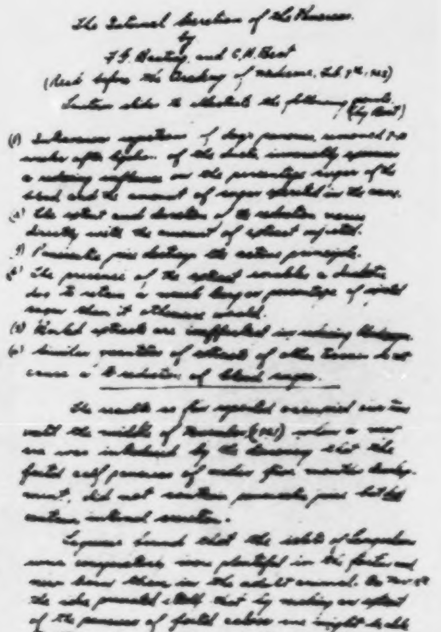
Another step was taken by the Legislature to secure the jurisdiction of the Board. Unable to carry out medical examinations of school children on its own initiative, the provincial Board had long felt that its public health role was being interfered with by the Department of Education. The members of the Board were delighted when legislation granted them and local boards of health sole authority to carry out medical and dental examinations in public and separate schools throughout the province.

In 1923, the Provincial Board of Health in conjunction with the University of Toronto and the Connaught Laboratories began to distribute free insulin to diabetics. It had been two years earlier at the University of Toronto that Dr. Frederick Banting and his assistant, Charles Best, had discovered the role of this insulin hormone in diabetes. It had been prepared for clinical use the following year. The Nobel Prize was awarded for the discovery of insulin, considered the most important breakthrough in 20th century medicine. It provided a major impetus for medical research not only in Ontario but in the rest of the country.

Also in 1923, in what appears to be an attempt to circumvent the continuing reluctance of the TB sanatoria to set up clinics, the Board organized the Travelling Diagnostic Chest Clinic. The ubiquitous "TB Clinic" would be remembered by generations of Ontario school children as the provider of an hour's freedom from school each year.



Dr. Frederick Banting and Dr. Charles Best with the first page of the original manuscript which announced their discovery of insulin



First page of the original manuscript announcing the discovery of Insulin.

The care of children's teeth was a subject of concern to the Department of Health. Dental Health Day was instituted in 1925 to create an awareness of oral hygiene, and free examinations and x-rays were offered at the CNE by the Division of Dental Services.

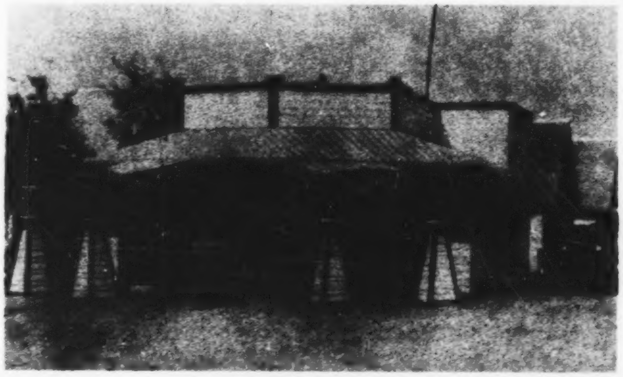
With the appointment in the same year of Forbes Godfrey, M.D., as Minister of Health and Labour in charge of the provincial health board, a member of the medical profession was placed in overall charge of public health for the first time.

Change was in the air. An act of the Legislature created the Department of Health in 1924. Public health now had a department of its own and was no longer linked with labour. At last it was given the prominence it deserved as, in the words of Dr. Bowditch years before "the most important matter any community can discuss."

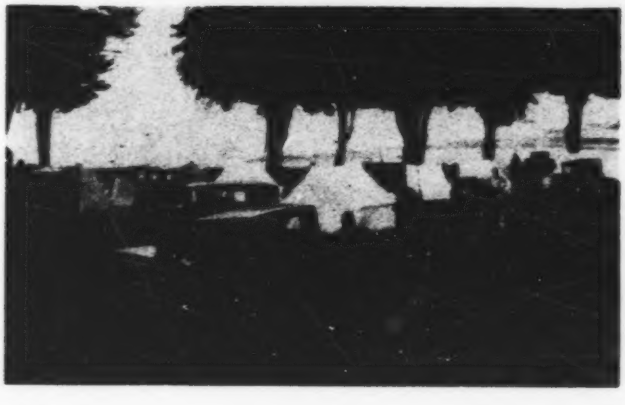
One of the first items to be taken up by the new Department of Health was the alarming condition of the teeth of Ontario children. More than 200,000 little mouths were looked into and no fewer than 92 per cent of them were found to have a dental problem of some kind. In response, the worried Department mounted a swift campaign to reverse the situation. The province's first Dental Health Day was held on October 20, 1925. At the Canadian National Exhibition, the Department's Division of Dental Services offered free examinations and x-rays.

By the middle of the decade, with the growing popularity of the automobile, tourist motor camps and highway refreshment stands were beginning to spring up The Department branched out to anticipate public health and safety problems New standards were brought in to regulate summer resorts, hotels and restaurants. Sanitary conditions at boys' and girls' summer camps were subject to strict controls. The arrival of electricity at the lumber camps in Northern Ontario wa greeted with enthusiasm by the Department because electricity meant there would be hot water and good lighting - both aids to cleanliness.

In spite of many public health improvements, there was still no legislation requiring the pasteurization of all milk Two U.S. embargoes on Ontario milk because of a fear of typhoid fever contamination allowed Department officials to point out that health conditions weren't only a domestic concern when they interrupted foreign trade. But it was not until 1938, 11 years later, that legislation was passed requiring compulsory pasteurization of all milk and cream in urban, and certain designated rural, municipalities.



As automobile travel increased, the Department moved to regulate sanitary conditions and public safety in summer resorts, hotels and restaurants. A highway refreshment stand displays an approved sign to catch the attention of passing motorists.



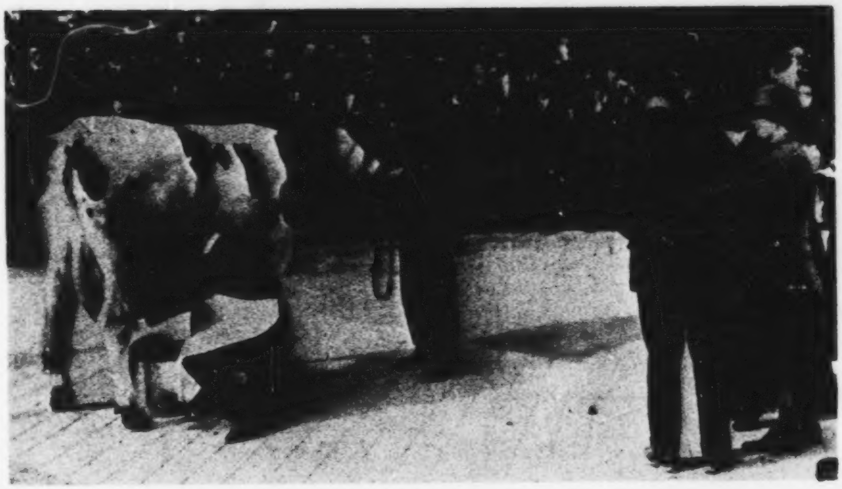
Tourist motor camps were als subject to new public health and safety standards.

Some of the public health regulations that came into effect in the latter part of the decade are now taken for granted. Sanitary conditions began to be closely governed by the Department in abattoirs, chicken slaughterhouses, bakeries and in cheese and ice cream factories. The common drinking cup at fountains and other public places was abolished as well as the single, common towel in public washrooms.

Late in the summer and early fall of 1[illegible]9, there was one of the most severe and widespread epidemics of polio ever recorded in the province. Of a total 558 cases, 46 people died.

Before the end of its fifth decade, the Department of Health moved from "The Spadina House" to the new East Block of the Legislature Buildings.

Fifty years of work to improve health in Ontario was resulting in a growing public awareness of what was at stake. Fewer people were living in miserable, unsanitary conditions; fewer workers were toiling in sweatshops; and fewer citizens were dying of preventable diseases.



Healthy cows and immaculate cowsheds were important in the fight against typhoid fever and tuberculosis. The Minister of Agriculture, Manning Doherty, is pictured here in 1921, at the opening of a pure milk campaign in front of the Ontario Legislature.

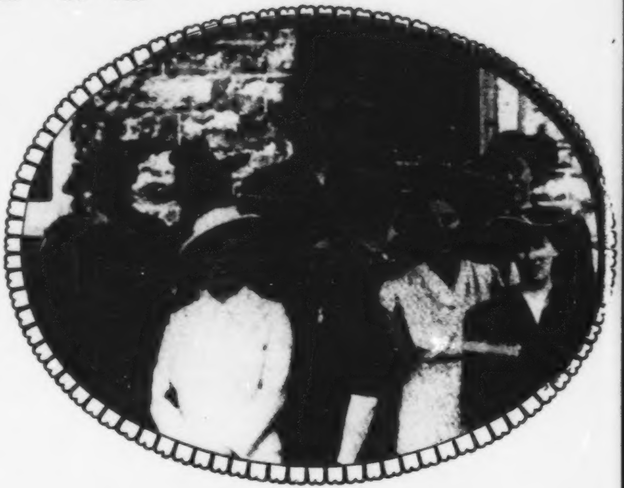
VI — The Sixth Decade — 1932–1942

It is ironic that it was during the "Dirty Thirties" that some of the most significant steps were taken in the evolution of the province's health system.

In 1933, with the Great Depression well underway, representatives of the Department of Health met with the Canadian Hygiene Council to discuss a proposed campaign to promote dental hygiene. It would concentrate on nutritional education and undertake considerable dental work. Because of the Depression, the program was made part of the Department's general relief program. It began as a trial project in Southeastern Ontario, and was the beginning of the health unit network as it is known today.

From the beginning there was enthusiastic support for the program. The Ontario Dental Association contributed $1,000 toward producing literature about oral hygiene. The Royal College of Surgeons lent the services of its field secretary, and the Ontario Medical Association contributed educational funds.

The core of the medical health personnel working in the program was made up of the Department's eight public health nurses and one physician already in the area. All dentists and physicians practising in the selected counties of Stormont, Prescott, Glengarry and Russell were part of the program and worked under the Director of the Dental Services Branch and the Director of the Division of Maternal and Child Welfare and Public Health Nursing.



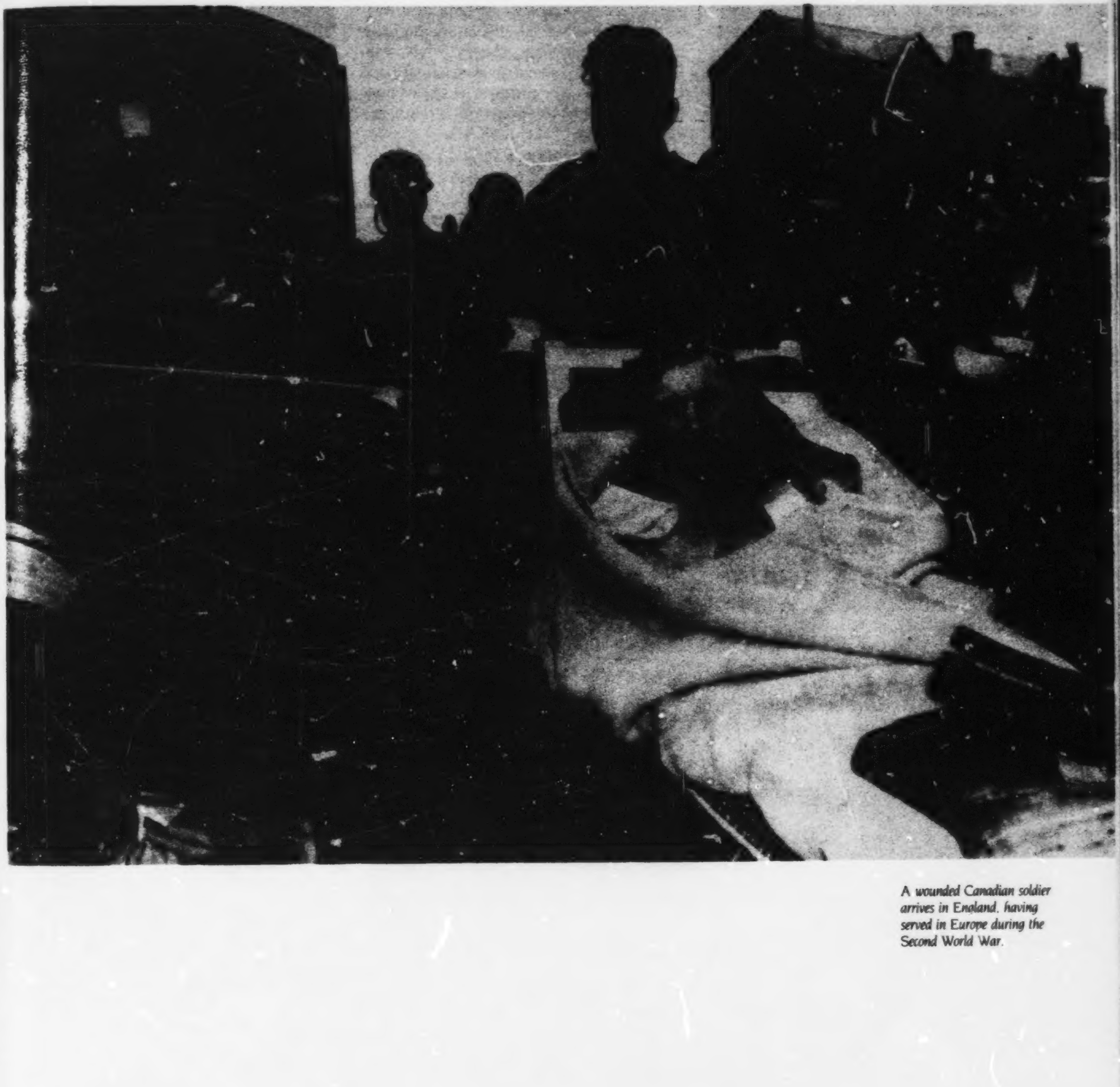
Members of the staff of the Eastern Ontario Health Unit, established in 1935. Medical health personnel included eight public health nurses and one local physician. Today there are forty-three health units and departments of health serving the province.

During the first year, the success of the trial project encouraged the Department to request financial assistance from the outside. The Rockefeller organization, in the United States, granted $33,000 to help operate the unit for its first five years. On January 10, 1935, the *Eastern Ontario Health Unit* officially began to function.

Born during the Depression, it was the first of the 43 health units and departments of health that serve the province today, and was headed by a full-time director, who was a doctor with special public health qualifications. The staff included eight public health nurses, two from each county, a sanitary engineer and a chief statistician. The Department of Health took advantage of the organization of the health unit to obtain complete records of births, deaths and communicable diseases. It was hoped that increased health consciousness would result from improved reporting of disease.

The administration of the province's public hospitals, hospitals for incurables and sanatoria had become the responsibility of the Department of Health in 1930. The Hospitals Branch of the Department took charge of mental hospitals in 1931. All hospitals had once been the responsibility of the Office of Inspector of Prisons and Public Charities. The final consolidation of all hospital administration within the Department in 1935 ended the

In the 1930s dental clinics travelled from school to school, examining children's teeth.



A wounded Canadian soldier arrives in England, having served in Europe during the Second World War.

basic division of the public health care system into two categories of preventive medicine and active treatment. It changed forever the basic character of the provincial health care system.

During 1935, the Division of Industrial Hygiene listed silicosis first among industrial diseases known to cause permanent disability. It called for legislation requiring underground miners to be examined at the time of employment and every year thereafter. The division also took over responsibility for the direction of cancer control, an acknowledgement of the early suspicion of a link between many cancers and man made substances.

The establishment of the Division of Tuberculosis Prevention was an attempt to co-ordinate the work of prevention among medical officers of health, local boards of health and sanatoria, and to control the activities of the travelling chest clinics. Once again there was an underlying economic motive behind this administrative change. By detecting the disease in its earliest stages, which was the goal of the new division, treatment costs were greatly reduced — about one-third the cost of treating a moderately advanced case.

The one epidemic of typhoid that year occurred in Belleville and was traced to a water pump in the grounds of the annual fall fair. Otherwise, it was the lowest rate ever reported in the province. The incidence of polio was also down, although 1937 would bring the most severe epidemic in provincial history. It would strike 2,544 people throughout much of the province during the late summer and early fall and leave 109 dead.

The social and economic effects of the Depression were felt everywhere in the province. In a report on the home visiting program of the Eastern Ontario Health Unit, public health nurses said many families were so poor that little could be done about their health problems.

The stark hardships of the Depression in combination with an increasing need for greater public health care led to the Ontario government's province-wide Medical Welfare Plan for those on relief. The plan called not only for free medical treatment for those in need, but for free hospitalization and dental care as well.

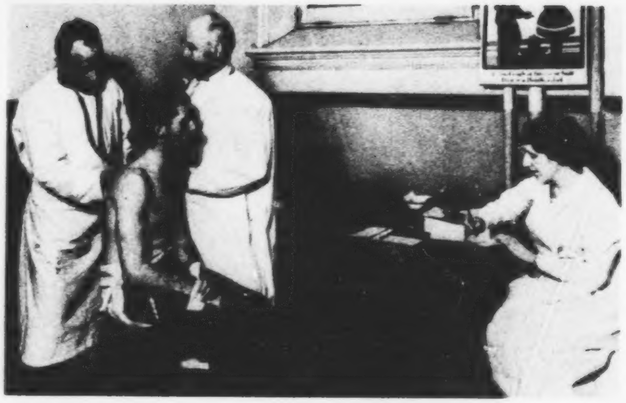
Three years later, in 1938, the province assumed the entire cost of sanatorium treatment for impoverished TB patients. Once again, the isolation and treatment of TB sufferers would prove successful in lessening the spread of the disease.

A second major victory for the Department of Health that year was the passage of legislation requiring the compulsory pasteurization of milk in all cities, towns and other defined areas. This move would put a stop, finally, to the spread of such contagious diseases as diphtheria and tuberculosis through the milk supply. In spite of decades of proof linking milk with communicable disease, this was the first legislation of its kind passed anywhere in North America.

With the coming of the Second World War in 1939, the Ontario Department of Health once again put all its resources at the disposal of the Federal Government. The services of its laboratories, the consultant staffs in epidemiology, tuberculosis, venereal disease and sanitary engineering were offered to the Department of National Defence. All biological medicines manufactured by the Department were given free for the immunization of enlisted men from Ontario.

The ranks of doctors, public health nurses and hospital workers were thinned as these people joined the forces, and the VD rate soared once again, though not as high as during the First World War. At the end of the sixth decade, the Department was still able to show a record low in the death rate for tuberculosis, pneumonia

A display of biological products and x-ray services provided free by the Department of Health



During the 1930s, chest clinics worked to detect tuberculosis in its earliest stages. In 1938 the province assumed the whole cost of sanatorium treatment for impoverished TB patients.

Dr. Norman Bethune
1890–1939

and bronchitis, and a decrease in the infant mortality rate. Ontario now possessed one of the lowest infant mortality rates in the world. The growing effectiveness of public health care in Ontario was undeniable.

The 1930's saw the widespread use of the sulfa drugs to treat bacterial infections and the first use of electroshock therapy for the mentally ill. It found Canadian doctor Norman Bethune doing pioneering work in chest surgery in Montreal and in blood transfusion in Spain. In 1937, throughout Canada, the first health insurance scheme began; mothers began feeding their babies the new Canadian miracle food, pablum, and the Dionne quintuplets were born.

It was quite a decade. There was a lot of reason for Ontario's Chief Medical Officer of Health Dr. J. T. Phair to write near the end of it, "The day has gone when the Health Department staff consisted of a man with a tack hammer and an arm full of colored cards, and a physician employed part-time. . . ." It certainly had.

World attention was focused on Ontario when the five Dionne babies came into the world.

VII — The Seventh Decade — 1942–1952

During the early struggles for such essentials of public health as municipal sanitation and decent housing, the provincial Board had to contend with a mood of public indifference. But gradually, as recommendations became regulations that were seen to be effective in reducing infectious disease, the public mood shifted; a greater desire for protection and guidance in health matters became evident.

The Department of Health and its predecessor, the Board of Health, could be credited with instilling in the public a belief in the values of speaking out for things such as air and water quality, decent housing for all and safe working conditions.

By the 1940s, public health officials had been fighting for 60 years for all of those things and more. For most of those 60 years, they tried to engender a new public mood, because few people in the late 1800's and early 1900's saw any use in municipal sanitation or better living conditions for ordinary workers and farm laborers. The idea that clean water and clean air were worth fighting for was an idea born within the public health system.

In the first years of the decade, the war naturally took precedence over everything. Biological drugs, revenue and health care workers at every level were diverted from the Department to the war effort. Yet ironically, the Second World War helped Ontario's health care system win acceptance of the need for public health measures. The Chief Medical Officer of Health, J. T. Phair, in his 1942 Annual Report said that, while promotional efforts of health workers "are received indifferently in times of peace," in times of disaster the "popular interest in the health and well-being of the citizenry is readily aroused."

In the field of nutrition, particularly, there was a new receptiveness and a demand for information. Perhaps food rationing had created a greater awareness of making the most of what was available.

The war helped to advance VD control. When measures adapted for the military were applied among the civilian population, they resulted in improved VD control. Toward the end of the decade, there was a growing acceptance of penicillin as an effective treatment for syphilis and gonorrhoea. It was the first of the antibiotics which have become so important in the treatment of infections.

But the war hampered the battle against TB. A shortage of health personnel and overburdened clinics made the effort to control the disease through treatment and isolation more difficult. Certain features of wartime life such as longer working hours, crowded living conditions and, to a limited degree, food rationing, were factors in the increase in the TB mortality rate. Mass screenings, including the Hospital Admission Chest X-ray Program, and better diagnostic networks were resulting in more discovered cases, and more cases were also being uncovered in the armed forces. Additional beds and adequate x-ray facilities were urged, to be paid for out of public funds. Every discovery of a case of TB which led to isolation and treatment diminished the threat of the disease spreading.

There had been no sanatoria constructed since before the war, but the postwar building boom meant new sanatoria as well as renovations and additions to existing ones. This, along with the discovery of anti-TB drugs during the 40's resulted in a decline of the TB mortality rate by the end of the decade.

War brought food shortages and rationing. Department pamphlets encouraging the use of even the last stale crust of bread included recipes for sheep's head pie and cheese pudding.

Dr. J.T. Phair, Chief Medical Officer of Health, is shown conducting an examination at a child welfare clinic during the 1930s.

The provincial government's Capital Grant Policy of 1947 meant construction grants to public hospitals of $1,000 per bed for active treatment and $2,000 per bed for chronic care. These construction grants sparked the building of hospital space for 10,000 beds in general hospitals and another 1,900 beds for the chronically ill.

With the new construction and other changes taking place, the hospital field was busier between 1945 and 1950 than it had been during any time in the preceding half century. To supervise this new world of hospital business, the Division of Public and Private Hospitals was organized within the Department of Health. At the end of 1951 the new division was faced with a total of 175 hospitals with 21,000 beds. Those hospitals were treating about 600,000 patients a year for about seven million days of care.

To meet the added demand for nurses a grant program was sponsored by the province for the construction of nurses' residences. Nine Ontario communities built what the department described as "splendid residences" between 1945 and 1950. Other communities improved their nurses' residences or built new nurses' quarters for their local hospitals. It was quite a change from the days when municipal councils expected nurses to put up with two-to-a-bed dormitories with rats running around.

The Nurses' Registration Division was renamed the Nursing Division of the Ontario Department of Health and became responsible for the supervision of nursing schools and the training and registration of certified nursing assistants. It also improved the curricula of nursing schools to meet new demands for preventive treatment and the new emphasis on the psychological aspects of medical treatment.

Today, much of what was once under the jurisdiction of the Department is managed and supervised by other ministries of the provincial government. The maintenance of water quality and air purity, for instance, is now the responsibility of the Ministry of the Environment.

But by the end of the seventh decade, the Department of Health comprised 13 divisions and a library. Two important additions in 1944 were the Division of Public Health Nursing and the Division of Psychiatric Nursing. A separate division for nurses specializing in mental illness was needed to cope with the demands being made on mental hospitals. Through the late 1940's the number of elderly patients admitted to these mental hospitals continued to grow at a steady rate. As well, the war had left some of its casualties in these hospitals.

In 1951, there was a new approach to the treatment of mental and nervous diseases in Ontario.

Around 1948, nurses in training relax outside their Port Dalhousie residence. The residence was part of the Mack Training School for Nurses, founded in St. Catharines in 1874.

Psychiatric nurses in training at London Psychiatric Hospital School of Nursing in 1928. The school no longer exists.

The Department of Health decided to encourage the building of psychiatric units in general hospitals. The province granted $8,500 per bed to the public general hospitals so they could provide more local psychiatric treatment. These general hospital clinics would serve both in-patients and out-patients but would be limited to six per cent of the hospital's total bed capacity. This decision began a long-term drive that would eventually conquer much of the public's fear and ignorance of mental illness; it initiated a trend toward community care where possible and away from confining the mentally ill in institutions.

The Division of Industrial Hygiene continued to work on improving the general health of industrial workers, including forestry workers and miners, and providing protection from specific health hazards connected with working conditions. Inspectors from the division enforced regulations under the Public Health Act. Industries under close watch were those that used such deadly substances as arsenic, beryllium, lead, radioactive substances, silica, benzol and explosive dusts.

Of particular and growing concern to the division were the occupational hazards and life-threatening potential of industrial exposure to radium, x-rays and gamma rays. Inspectors were increasingly on the lookout for evidence of occupational cancer. They found links between skin cancers and cutting oils and compounds. Indeed, the most prevalent ailment of factory workers, according to the division's findings, was skin disease. Inspectors estimated that 60 to 70 per cent of all occupational diseases were "skin eruptions."

They were also conducting air sampling in plants where such substances as lead dust and fumes were generated and were persuading plants to set up their own air sampling programs. In one instance, the inspectors did a special study of the practice of backing mirrors with lead. One man had suffered lead poisoning while spraying a lead compound on the mirrors. The solution was to apply the backing with a brush instead of a spray gun.

For decades, the Division of Industrial Hygiene had been trying to persuade employers to establish health centres in their plants for employees. In the early 1950's, the Division also made a special effort to keep the province's doctors abreast of new and potential health hazards in the workplace.

During the seventh decade, the Division of Medical Statistics gathered cancer statistics. The Ontario Cancer Centres at Toronto, Hamilton, London, Kingston, Ottawa and Port Arthur kept case records and follow-up cards on every patient. The division prepared statistical summaries for each centre; treatment results were tabulated and analyzed, showing the exact measure of success of particular treatments of specific cancers.

Studies on the incidence and prevalence of cancer and analyses of cancer mortality rates in Ontario were undertaken, as well as a five-year study comparing cancer statistics in Ontario with those in Italy.

One of the iron lungs used by Toronto General Hospital in the 1940s. . .a reminder of the frightening consequences of the polio epidemics of those years.

The Division of Epidemiology had seen its task change radically in its lengthy history. The fear of such old-fashioned diseases as smallpox and typhoid had diminished to be replaced with concern over modern ailments such as polio and meningitis. By far the bulk of the work of this division was in combatting the still-common diseases of German measles, mumps and whooping cough.

There were still outbreaks of the pioneer diseases of diphtheria and typhoid fever. But the death toll from such ills was at an all time low by the end of the seventh decade, thanks to vastly improved sanitation and immunization. In fact, by 1951 the province had been totally free of smallpox for 18 years.

The world had come a long way from the pandemics of the 1800's that spread diseases such as typhoid and smallpox across the oceans. As soon as an influenza epidemic broke out in Northern England, word of it sped through North America from the Influenza Information Center in Washington, D.C., and all health departments were placed on the alert to guard against outbreaks in the U.S. and Canada.

It was polio that was the real scourge, and that was a domestic disease. In 1951, the province fell victim to the worst incidence of poliomyelitis since 1937 when 119 people had died. This time there were 1,699 cases of polio recorded, with 78 deaths. Throughout the 40's and into the 50's, the polio rate had been climbing. Fortunately though, the majority of cases were of a non-paralytic type of the disease.

Treatment for polio, however, had been improving in the late 1940s. During one year, 104 polio victims were kept alive in iron lungs. The wards that housed them were desperately sad places, filled with the loud rhythmic wheezing of the respirators. But a polio breakthrough was just around the corner.

WARNING
THE PUBLIC ARE WARNED OF THE POSSIBLE DANGER OF INFECTION AND DISEASE IN BATHING IN THE WATERS OF THIS LOCALITY

VIII — The Eighth Decade — 1952–1962

The fabulous fifties gave us Elvis Presley and rock and roll, but they also brought a dramatic medical breakthrough with the Salk vaccine for polio. The eighth decade saw an end to the Korean War and a beginning of the serious medical war against cancer.

The Ontario Cancer Institute Act of 1952 incorporated the Ontario Cancer Institute of Radiotherapy, giving the Department the authority to plan, construct and operate clinics and premises for cancer research and for the diagnosis and treatment of cancer.

The decade brought a variety of important, streamlining changes to the Department of Health, a tremendous increase in the use and growth of the hospital system in the province, and the beginnings of the Ontario Health Insurance Plan.

During the forties, high employment and greater involvement by the public in private hospital insurance plans resulted in a sharp increase in the use of Ontario public hospitals. In 1952, 15 per cent of the population received hospital care, compared with 10 per cent in 1943. In the same year, 71 per cent of the province's births took place in hospital; nearly 10 years later, 92 per cent of the total number were hospital births.

By 1952, with the help of the federal government and the provincial government's capital grant policy for hospital construction and expansion, Ontario had 22,206 hospital beds to serve a population of 4,766,000. The province had committed $29 million to the construction program since its inception in 1947.

Dr. Jonas Salk administering the vaccine that he developed in the United States. The vaccine used throughout Canada was produced by Connaught Laboratories and distributed free.

These beds were to prove necessary. In 1954, polio swept through Ontario in another record outbreak. There were 1,109 cases, many of them the paralytic variety, and 118 deaths. Muskoka, Simcoe, Halton and Waterloo were among the counties hardest hit. During the year, the disease had cut its path through the western provinces as well.

Scientists had already noted that polio spread most rapidly during the hot summer months when people gathered at beaches and public swimming pools. During the winter, the incidence of polio was very low. The prospect of spending one's life seriously crippled or completely paralysed or dependent on an iron lung for breath, made polio a terrifying disease. During an epidemic, beaches and public swimming pools were deserted. But one year after the big epidemic of 1954, the anxiety and empty beaches were to be a thing of the past.

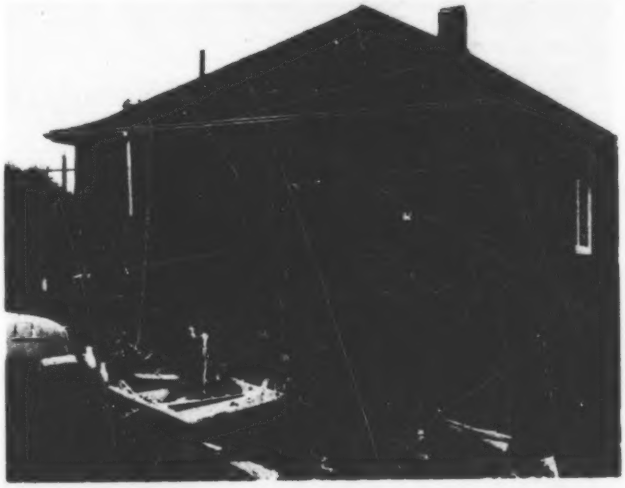
Before the free Salk vaccine inoculation program could begin in Canada, technicians at Connaught Laboratories ran thousands of tests on the vaccine.

Dr. Jonas Salk had perfected the vaccine that bears his name, and in 1955 Ontario received a supply, and the Department provided vaccine for children in grades 1, 2 and 3 in all elementary schools.

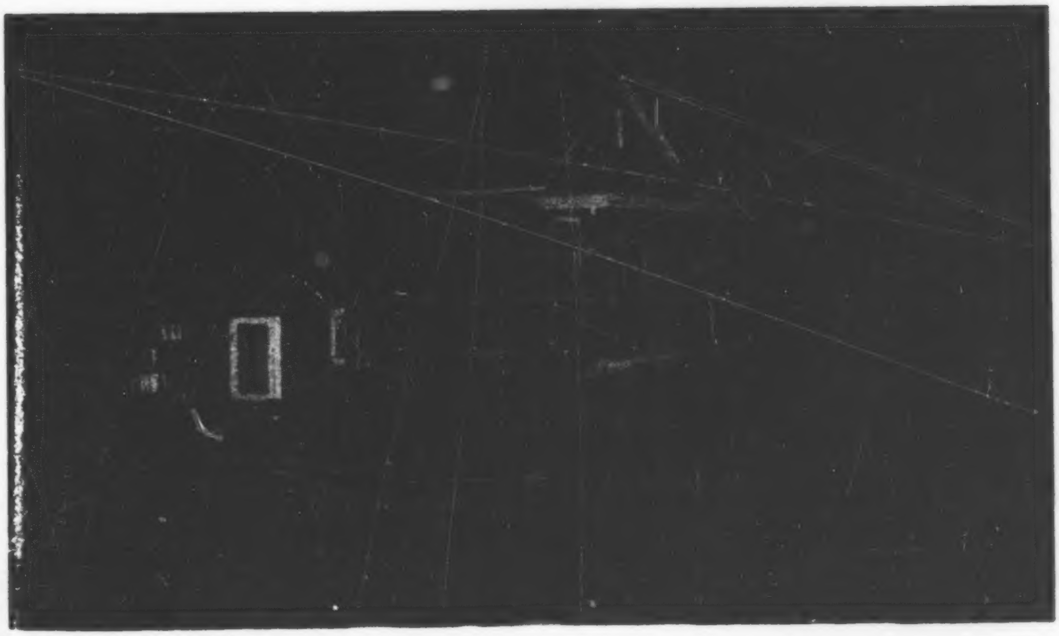
It was distributed to local medical officers of health over a three-month period. In that early summer of 1955, 686,254 single doses of vaccine were distributed – enough for a two-dose inoculation of more that 343,000 children. There were no severe reactions reported.

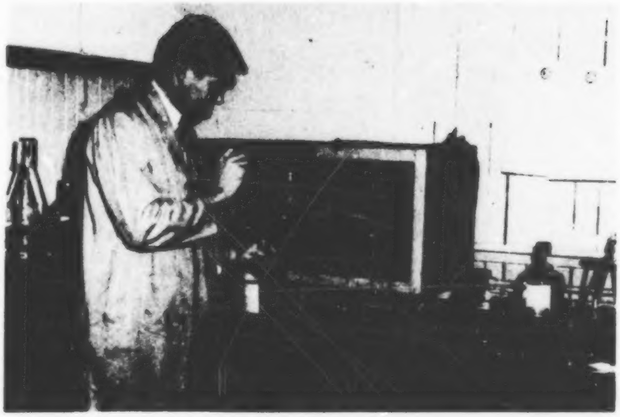
The distribution of the Salk vaccine showed the effectiveness of the public health unit system, both provincial and local, that had been built during 75 years of organized health care. The results spoke for themselves. Near the end of the eighth decade of the Department of Health, polio had succumbed to the vaccination program; only 20 polio cases were reported in 1958, of which 15 had not been vaccinated.

The organization and professionalism of the public health operations in the province had already been demonstrated in 1954, when Hurricane Hazel devastated parts of Toronto and its suburbs. The hurricane brought unprecedented flooding and destroyed dozens of houses. Much of the city's lakefront and many of its riverbanks were left littered with debris, sewage and the bodies of dead animals, including pigs from a local farm. Yet there was not a single case of typhoid or any other serious infectious disease as a result of the flooding.



Hurricane Hazel put public health workers to the test. In spite of property destruction and widespread flooding, there was not a single case of typhoid fever.





Biologist at work in the first Ontario Water Resources Commission Laboratory in Toronto. The Commission was given responsibility for all water supplies and sewage disposal systems in the province.

In general, the incidence of infectious diseases was the lowest on record for the province in 10 years, reflecting again the continuing effectiveness of immunization and public sanitation. Diphtheria, typhoid and other serious diseases had been beaten back, partly due to the fact that 99 per cent of the province's milk supplies were now pasteurized. The minor diseases such as chickenpox, German measles and mumps were under control. In 1954 there wasn't a single case of smallpox reported in Ontario.

Yet another dread disease was fast disappearing. The TB death rate had fallen to a new low of 2.3 persons per 100,000 population. Beds in the province's TB sanatoria were emptying. Treatment programs reaching into northern Ontario brought more than 200 Eskimos and Indians south in 1955, but by the year's end there were plans in the Department to use the many empty beds for patients suffering from other ailments.

Meanwhile, the Department's expanding rehabilitation program was moving into northern and eastern Ontario where discharged TB sanatoria patients and people left disabled by polio were trained and helped in finding work. These rehabilitation activities were to grow and assume a major role within the public health care system.

During the 1950's, health care systems throughout the West were taking a hard look at mental illness and mental institutions. Many of these places were vast, forbidding hospitals that acted more as prisons than as treatment centres. Ontario had also been studying the many problems of treatment for the mentally ill and, as has already been described, had been encouraging the use of psychiatric units in general hospitals. These developments were speeded up as a result of the development, during the 1950's, of psychotropic medications. The medications were so effective in controlling symptoms of mental disorder, that in many cases patients were hospitalized for shorter periods, or could be treated on an outpatient basis. Many formerly chronic patients were discharged from hospital, making a reduction of psychiatic hospital beds possible, and making the treatment of psychiatric patients in general hospitals more feasible.

The Mental Health Act of 1954 dealt with alternatives to the traditional mental hospitals. It regulated a different kind of care in the new and growing field of community mental health projects, which included mental health clinics, child guidance clinics and community psychiatric clinics. There was immediate response to the demand for such new services: in 1954 alone, a child guidance clinic was opened in Ottawa Civic Hospital; a 52-bed psychiatric unit opened at Victoria Hospital, London; a 30-bed psychiatric unit opened at St. Michael's Hospital, Toronto; and another 30-bed unit opened at Sudbury General Hospital.

The Division of Sanitary Engineering had been responsible for encouraging and overseeing the building of almost all major water and sewage disposal systems in the province; and it had sponsored

The gloomy skies in this nineteenth century engraving of the 999 Queen Street West Hospital were in keeping with the prison-like atmosphere of mental hospitals at the time.

Sudbury Memorial Hospital, built in 1956

Northwestern General Hospital, Toronto, built in 1952

North York Branson Hospital, opened in 1957

much important public health legislation, including the law for the pasteurization of milk and regulations for slaughter-houses and meat-packing plants. After more than 60 years of work within the Department, the division was removed from the Department of Health in 1957 and made an independent body. The Ontario Water Resources Commission, as it was known, took with it all responsibility for the water supplies and sewage disposal system of the province.

Within the Department, the new Division of Environmental Sanitation was created to continue with the remaining work of the old division, including the overseeing of private water supplies, sewage and waste disposal. The new division also administered the Environmental Sanitation Training Centre, which trained sanitary inspectors.

The year before, the Department had made another move to accommodate its administrative structure to changing demands on the public health care system. All the duties of the Division of Public and Private Hospitals were transferred to the newly legislated Hospital Services Commission of Ontario. The new commission was to continue to administer the payment of grants to hospitals, among its other inherited duties; but it would also be responsible for creating, organizing and administering any hospital care insurance program undertaken by the provincial government. It would be the commission that would shepherd into being a hospital insurance plan for Ontario.

In preparation for such a plan, the commission made a survey of hospital facilities and staff and met with representatives of the various groups that would be affected by such a program.

Preliminary studies led to the drawing up of a new act that would become the cornerstone of modern medical care in Ontario: The Hospital Services Commission of Ontario Act of 1957.

The province also submitted a formal proposal to the federal government which would eventually share the costs of the plan as part of a nation-wide health insurance program.

By 1959, the Ontario Hospital Insurance Plan for Ontario became effective.

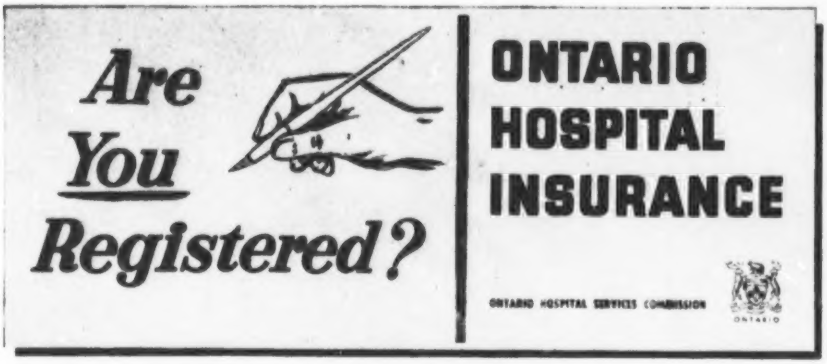
Every citizen of the province was now assured of getting hospital and medical care when necessary regardless of income and, most important, without being described as a ward of the public.

Before this, the Department of Health had been primarily involved with the operation of provincial psychiatric hospitals and facilities for the retarded, with TB sanatoria and with the provision of health services by local health units.

Throughout the 1950s, the Department's health units were multiplying rapidly. In 1954, there were 27 health units in the province; six years later, there were 34. By 1961, with the opening of the 35th public health unit in Waterloo County, about 80 per cent of the province's six million or so people were receiving public health services through local boards of health employing full-time medical officers of health, public health nurses, sanitary inspectors and other trained personnel.

During these years, more than one million pieces of literature had been sent to schools, individuals and social groups advising citizens of ways to safeguard public health. The Department's messages were seen on television and heard on radio. Public health displays were still a feature of almost every fair and exhibition.

The last year of the decade was the first year on record in which not a single polio death was reported in all of Ontario. The tuberculosis death rate had fallen to a new low of about 2.3 persons per 100,000 population.


Are You Registered?
ONTARIO HOSPITAL INSURANCE
ONTARIO HOSPITAL SERVICES COMMISSION
ONTARIO

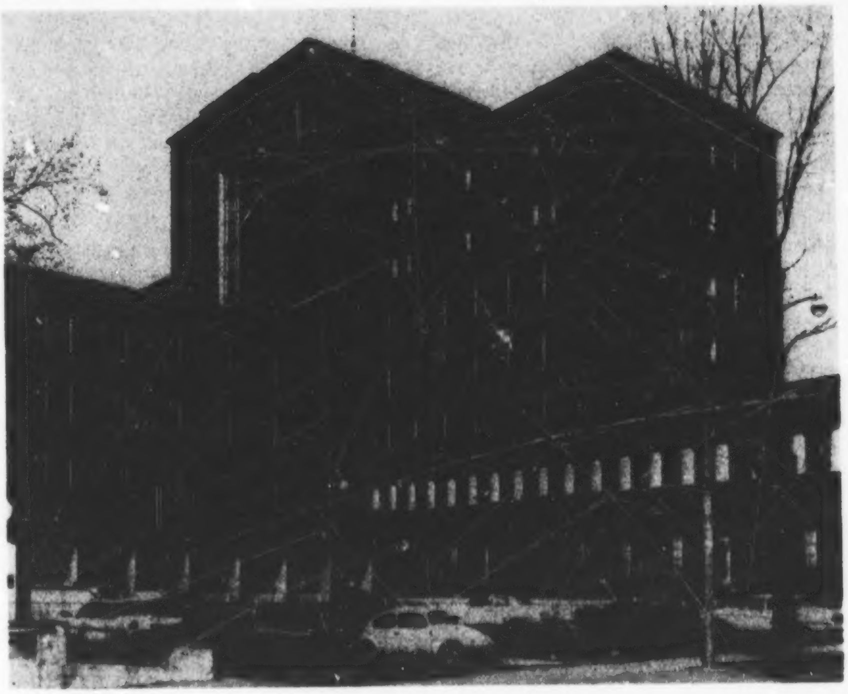
This billboard reminder was displayed at 158 locations in the province during August and September of 1958.

Between June and December of 1958, twelve women took an average of 5,000 calls a week, answering questions about the new insurance plan.

This brochure, produced by the Department of Health and distributed to the general public, introduced the public health nurse, and described her duties and responsibilities.

The decade ended with the Department of Health's supervision of milk production — through local health agencies — being transferred to the provincial Department of Agriculture. The Department was saying goodbye to a success story. Because of the encouragement and even the bullying of health officials in the province, milk sold throughout the province was safe from disease and contamination. There were now 473 pasteurization plants in Ontario and contaminated milk, causing diphtheria and TB, was gone forever.

The Department's responsibilities were more changed than lessened, however; the air pollution branch had come into being in 1958 and was showing considerable progress. Also, near the end of the 50s, the fledgling Ontario Cancer Treatment and Research Foundation was an excellent example of the modern facilities available for research and treatment. Under the aegis of the Ontario Cancer Institute, Princess Margaret Hospital was opened as a cancer treatment centre for Toronto. It has continued to be the central facility for cancer treatment and research.



Princess Margaret Hospital, Toronto, photographed in 1958, the year it opened

The Department of Health faced its ninth decade with new battles to fight and new fields to conquer. Officials were investigating ways to integrate the mentally ill and the discharged TB patient back into the community. Syphilis was on the upswing, and infectious hepatitis, for which there was no vaccine, was a growing concern. The Department's research found that poor nutrition was widespread, especially among teenagers. Clearly, this was an area for better education.

From a quiet start, the 50's had turned out to be an exciting and a changing decade for Ontario's health care system, and a harbinger of things to come.

IX — The Ninth Decade — 1962–1972

Health care has not been without its setbacks and tragedies. In 1962, medicine throughout the western world, with the exception of the United States, suffered one of those tragedies when the drug Thalidomide was prescribed for nausea in expectant mothers. It was not known that the drug could cause serious deformities in the unborn.

Once the enormity of the tragedy was realized, the Department of Health in Ontario acted swiftly. With the full co-operation of all the general hospitals in the province, it began a study of all birth records for 1961 and 1962, the critical years. The researchers found nine infants with severe deformities, eight infants with moderate deformities and six who showed minor or slight deformities. The mothers of all these children had taken Thalidomide. The Department contacted all physicians involved with these cases to make certain the children would receive all surgical and rehabilitative care needed. Any part of the expenses for care not covered by insurance was taken up by the federal and provincial governments.

Two other affected children were later brought into the province by their parents, raising the total number of Thalidomide victims in Ontario to 25. Of that number, 20 infants took part in a program of financial help for medical treatment, drugs, x-rays and surgery.

The goal of a health care system is a population of healthy human beings; there is no better place to start in achieving this goal than among children who, in the 1960s, made up well over one-quarter of the population of Ontario. If the focus of the turbulent decade was on any single group, it was on the children.

The general health of Ontario children was good by 1962, thanks to special efforts in improving such areas as dental health and nutrition. The infant mortality rate was dropping steadily. Medical science had all but conquered most of the severe infectious diseases of childhood.

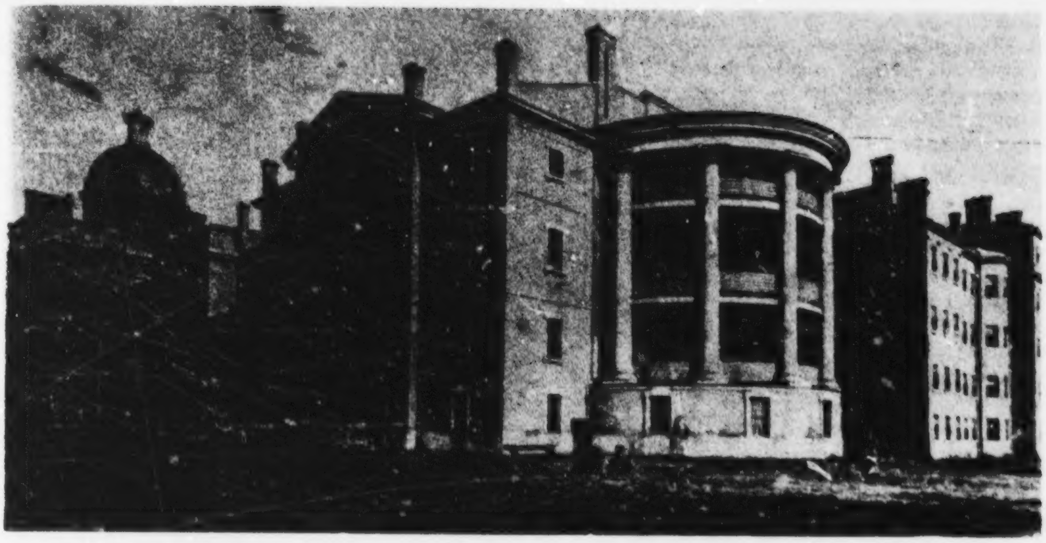
However, studies had revealed areas of special danger for children. It was shown, for example, that children under four years of age were most frequent victims of accidental poisoning, with the most common agents being household products and drugs. More than 30 poison control centres were set up to deal with this hazard.

The complete health and well-being of a child is more than a physical matter. The needs of emotionally and mentally disturbed children were not overlooked by the Department. The Minister of Health, Dr. Matthew Dymond, suggested to the Legislature a co-ordinated action involving the identification of those children in need of help and the further development of services for prevention, diagnosis, treatment and rehabilitation. His recommendation that these services for mentally and emotionally disturbed children be available at the community level resulted in today's network of Regional Centres.

Then, in 1969, to complete the picture, The Children's Mental Health Centres Act was passed, and the Children's Services Branch was created within the Mental Health Division. By this Act, all special treatment centres for children and adolescents suffering from mental and emotional disorders were brought under the jurisdiction of the Department of Health. At the end of the ninth decade — in 1971 — the authority for supervision, licensing and funding of private treatment facilities for emotionally disturbed children became a responsibility of the new Ministry of Health.

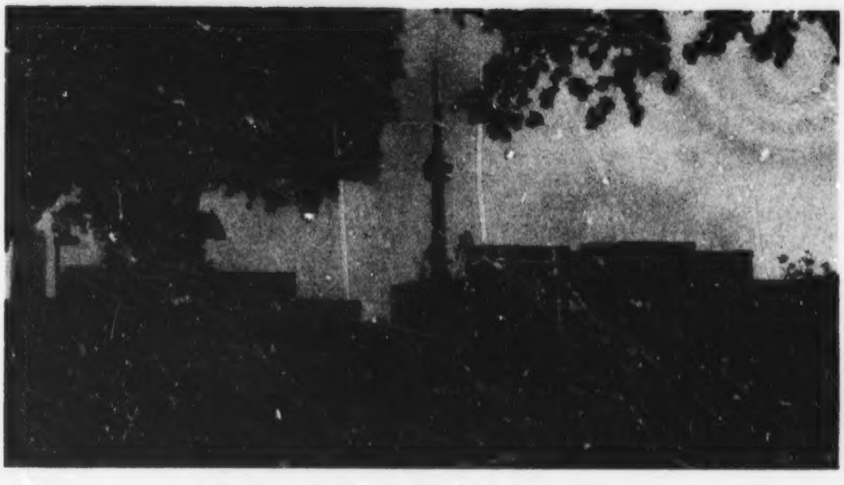
Improvements in the overall mental health facilities of the Department were made throughout the 1960's. The necessary foundations for these developments had been laid in the preceding decade when the Department decided to reduce the dependence of the mentally ill on large, often dehumanizing institutions, and to make treatment available in the community. The drive to develop comprehensive mental health centres in local general hospitals continued during the decade. By the end of 1964, there were 21 psychiatric units operating in general hospitals.

Dr. Matthew Dymond, Minister of Health from 1958 to 1969, pitches in and pours concrete at Whitby Psychiatric Hospital.



999 Queen Street West Hospital, photographed in the 1870s

The Homes for Special Care Program dovetailed with the new ideas and approaches of the Department to the treatment of the mentally ill. The program, begun in 1964, provided residential accommodation in the community for psychiatric patients who no longer needed active treatment in an Ontario hospital but who still needed help to live in a community setting. These homes for discharged psychiatric patients ranged from approved lodging houses and licensed nursing homes to licensed residential homes.



999 Queen Street West is a part of history. Today, the Queen Street Mental Health Centre in downtown Toronto is one of Ontario's busiest psychiatric hospitals.

Psychiatric patients were also referred to the Department's rehabilitation branch which in 1964 had 11 district offices. So many hospitals took advantage of this form of treatment that psychiatric cases represented 71 per cent of this branch's total caseload.

Those psychiatric patients who needed a conventional hospital setting for treatment were also well looked after. In 1970, one of Ontario's busiest psychiatric hospitals completely changed its character and shed an undeserved image. Toronto's 999 Queen Street Ontario Hospital was reconstructed and emerged as the Queen Street Mental Health Centre. The next year, Toronto Lakeshore Psychiatric Hospital (now closed) and London's Psychiatric Hospital, reached full accreditation status. In 1972 a 180-bed active treatment unit was completed at the Mental Health Centre at Penetanguishene.

In the ninth decade, the Department devoted special attention to the widespread abuse of society's common drugs: alcohol, tobacco and addictive drugs, both illicit and legal. The Department's rehabilitation branch had expanded its vocational and recreational program in 1963, to include a sheltered workshop for drug addicts and alcoholics. By the end of the decade, health officials were taking part in a plan to set up detoxification centres in selected areas of the province to deal with alcoholics during their sobering-up period.

"I seldom smoke on a date"
Cancer

Posters used early in the anti-smoking campaign illustrate two approaches to the problem of smoking and health. One bluntly links cigarettes to cancer, the other promotes the idea of smoking as a socially unacceptable habit.

Perhaps the most memorable health drive that was launched during the 1960's was the anti-smoking campaign. It began in 1964, when a Public Health Education Section, set up within the Public Health Administration Branch, went to work planning the role the Department would take in the national smoking and health subcommittee that was formed by the province, the Ontario Medical Association, the Ontario Division of the Canadian Cancer Society and the Ontario Tuberculosis Association. The program is still active.

Yet another group in Ontario that needed special attention from health officials was made up of residents of the more remote areas of the province. Most of these "unorganized" areas were, and are, in the north. Even though Northern Ontario had a system of health units, there were still some people who were not covered by these local offices of the Department or by local boards of health. To meet this need, the Northern Ontario Public Health Service Program was begun in August, 1962.

Timmins Regional Public Health Laboratory, one of many that serve the people of Ontario

Inside Timmins Regional Laboratory, specimens and cultures are examined.

This service offered school and home visits by medical personnel, clinics for infants and for immunization and contact with voluntary agencies which could help in a variety of situations.

By 1971, public health service was so improved in Northern Ontario that the special program provided direct care only in three districts, Algoma, Cochrane and Thunder Bay, and in part of another, the Patricia section of Kenora.

Ontario's great outdoors was attracting more tourists and vacationers each year, and recreational sanitation was becoming increasingly important. The Department of Health adopted the responsibility for protecting the well-being of vacationers and tourists as well as the province's residents. Public health officials, who at one time had trekked into the backwoods to visit lumber camps and mines, now forayed into the province's hundreds of summer camps and recreational facilities. Among the responsibilities the Environmental Sanitation Branch had inherited from the old Division of Sanitary Engineering was the administration of the regulations under the Public Health Act regarding these outdoor facilities. In 1965, the regulations for swimming pools were revised to give the medical officers of health even more control over hygiene and safety. In its work in the summer camps, the Branch co-operated closely with the Department of Lands and Forests.

On the front-line of modern emergency medicine is the ambulance. During the early part of the 1960's, ambulance services in Ontario were unco-ordinated and uncontrolled. In 1966, an Ambulance Services Task Force, set up by legislation, was designated to establish comprehensive plans for ambulance services across Ontario.

In the following year, the Emergency Health Service of the Department was established to improve, among other things, ambulance service. Ambulances were to be placed on a 24-hour footing and methods of administering emergency medical treatment to victims of accidents or mass disasters were devised. Training programs were initiated for ambulance attendants, hospital staffs and emergency medical volunteer groups.

With the passing of the Ambulance Act of 1968–1969, all the province's ambulance services, public and private, were brought under the Department of Health's authority. The Ontario Hospital Services Commission administered ambulance services and was given more active control over establishing ambulance services costs and standards. Licensing procedures were also revised by the Act.

During the 1960's there were to be other changes in the makeup of the Department. In fact, some of the most important changes in the Department's organization and in its direction were in store during the ninth decade:

- In 1963, four branches of the Department: epidemiology, TB prevention, laboratories and environmental sanitation, began reporting their activities under a single heading, the Communicable Disease Control Program.
- In 1964, the nursing branch added a new role when it began establishing consultative services in mental hospitals.
- In 1966, the Department of Health was entirely reorganized to keep up with the new areas of interest developing in the health care field. Now the Minister of Health would report to the Legislature on the activities of the Ontario Hospital Services Commission, the Ontario Cancer Institute and the foundations as well as on those of the Department itself. The Deputy Minister would co-ordinate the activities of these health-care bodies with the total health effort, while the main body of advice on health matters would be provided to the Department by the Ontario Council of Health.

The Department of Health was divided into four major divisions: mental health, public health, medical services insurance and financial and administrative services. Each division had a branch organization. The Public Health Division, for example, had four branches: Local Health Services Branch, Special Health Services Branch, Environmental Health Branch and Laboratories Branch.

- In 1967, the Task Force on Local Health Services recommended the amalgamation of all local health units and departments into 29 district health units. The establishment of these new, comprehensive units meant that, finally, all part-time medical officers of health would be replaced by full-time MOH's except for four isolated communities in the north. This had been a dream of health officials almost since the beginning of the system.

Emergency medicine depends on well run ambulance services. The Ambulance Services Task Force, established in 1966, co-ordinated ambulance services across Ontario.

- In 1968, a new Environmental Health Studies and Service was created to meet the growing need for investigation of the possible adverse health effects of long-term exposure to environmental contaminants both in industry and in the community. Beginning with the studies of industrial air pollution in Sudbury and the Windsor-St. Clair region, the investigation continued into other fields including uranium mining, refining operations and the rubber industry where workers came in contact with carcinogens.
- In 1969, the Ontario Health Resources Development Plan was drawn up. It was based on the findings of the Royal Commission on Health Services, conducted through the early 1960's, on the new insurance programs and on studies and advice from the Ontario Council of Health. OHRDP was to serve as a guide for the spending of more than $750 million over the late 1960's and the 1970's on the development of health-care manpower and the improved availability of services to all residents of Ontario.

ONTARIO DEPARTMENT OF HEALTH

- In 1971 the Department became the Ministry of Health.

Ministry of Health
Ontario

OMSIP represented an early stage in the development of Ontario's insurance plan.

Just as the Ministry was revamping its operations to tailor them to the modern medical atmosphere, the province was also making basic changes in and additions to its health insurance plans. The aim was to ensure that all Ontarians could make use of the health care system that had been built up. The health insurance programs, like the new organization of the Ministry, evolved swiftly through the ninth decade of health care.

The Ontario Medical Services Insurance Plan was introduced in 1966. OMSIP provided insurance on a voluntary basis for doctors' services and for specified dental services in hospital. It was offered not only to persons not covered adequately by private insurance plans but to pensioners and the self-employed. Assistance was also given to those in low-income groups who needed help to pay OMSIP premiums. In 1968, OMSIP services were expanded to include specified optometric services.

The Health Insurance Registration Board was set up in the same year to administer both the OMSIP and the OHSC plans and to collect premiums from both. Ambulance services had become another benefit of the OHSC plan.

The next important step in the rapid development of the province's health insurance programs came in 1969, when Ontario agreed to take part in a national plan under the Medical Care Act of Canada. The national scheme would see the federal and provincial governments sharing costs to provide almost every citizen with health insurance.

In Ontario, this plan took the form of the Ontario Health Services Insurance Plan, OHSIP, and was made available to all residents. Benefits under OHSIP included all medically necessary physicians' services; the plan would pay for such doctors' charges at the rate of 90 per cent of the fee set by the Ontario Medical Association. The benefits included specified optometric services and specified dental services in hospital.

In 1970, OHSIP coverage was expanded to include specified services of chiropractors, chiropodists and osteopaths. Also considered as OHSIP insured services were health examinations for school children, family planning and cancer detection programs.

OHSIP was born in 1969, when Ontario became part of a national health plan.

In many ways, the introduction of OHSIP on October 1, 1969, turned out to be the finest hour for the Ministry's highly experienced communications staff. OHSIP was offered to everybody in the province. That meant 7.4 million people had to be informed of how the insurance scheme could serve them. In a massive enrolment and publicity campaign, every householder in Ontario received a general information brochure giving all the pertinent facts of the new plan. Workshops were organized for medical secretaries and special bulletins were issued to the public and to the medical profession enlisting their support. In addition, OHSIP directors and senior Ministry officials met agents who would help the public to convert to the new insurance plan.

The success of this tremendous effort to organize the plan was to be seen in the fact that by the end of 1971, 99 per cent of the eligible residents of Ontario were covered by health insurance, and 1.3 million were receiving assistance in paying their premiums.

Another major program was hatched during the 1960's to ensure that all residents of the province would be able to afford and obtain health services. In 1970, the Ministry of Health brought in the PARCOST Program to guarantee that prescription drugs would be available to the public at reasonable prices throughout Ontario.

The decade of the 1960's may be remembered across North America in a less than glowing way. It saw widespread terrorism throughout the world, fierce unrest among the young and bitter warfare in various parts of the globe. But the 1960's should also be remembered in Ontario as a decade that saw the introduction of basic health insurance and the building of a system of health care that touched every region of the province and gave virtually all the people the basic care they needed.

X — The Tenth Decade — 1972–1982

During the 1970's, events moved so rapidly that time itself seemed to be going too fast, carrying us into the future before we were quite ready. There were discoveries every day in science, in medicine, in all branches of communication that made the new and exciting merely the expected. The total sum of human knowledge doubled from the birth of Christ to 1900, doubled again in the 50 years to 1950, redoubled in the 20 years to 1970.

The health care system in Ontario was part of this new rushing world. The availability of high technology and complex services, coupled with government-sponsored insurance plans, increased the public demand on the system. This led to greater supply and to yet more demand. At the beginning of the century, the health care system was far ahead of the general public, leading it toward better sanitation and preventive health. Now, after 90 years of existence, the system and the public had closed the gap. It did not, however, stop major health initiatives from keeping pace with public requirements.

A series of major moves began in 1972, at the start of the health system's tenth decade, with a truly universal health insurance program and structural re-organization.

On April 1, 1972, the existing hospital and medical plans were combined into one insurance scheme called the Ontario Health Insurance Plan, or OHIP. Under OHIP, almost seven million residents of the province were protected with family plan insurance, while another 1.3 million held individual policies. They paid a total of almost $520 million in premiums. In addition, the federal government, through the Medical Care Act of Canada, contributed $225 million to Ontario's OHIP coverage, while the provincial government made up the remaining cost of the system. Health care was now big business, a far cry from the days when the City of Hamilton, for example, could support its public health measures on $2,000 a year.

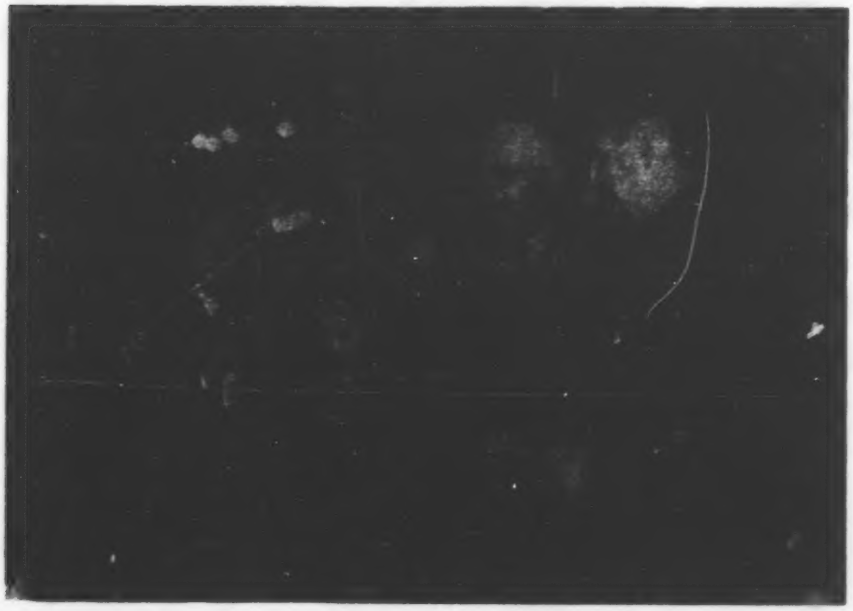
As the new health insurance program was starting up, the Ministry of Health was being restructured to accommodate this single, comprehensive plan which would serve the needs of the total population without restriction on age, nature of illness or other criteria. The plans for the restructured Ministry — which came into being the following year — called for a division into three operational units: health standards, health services and finance and information services. Each was to come under the direction of an assistant deputy minister.

During the 1973–74 fiscal year, increasing demand for hospital services continued, and hospital construction projects began to emphasize out-patient diagnostic and treatment facilities and the replacement of obsolete buildings. This marked the beginning of a trend throughout the province to more and improved treatment for the sick and disabled at the community level.

As a result of a Green Paper entitled "Community Living for the Mentally Retarded in Ontario: A New Policy Focus," published in 1973, another administrative change followed for the Ministry. On April 1, 1974, the mental retardation services of the Ministry were transferred to the Ministry of Community and Social Services.

The Developmental Services Act called for mental retardation units connected with psychiatric hospitals to become separate entities. This move was to pave the way for future delivery of services for the mentally retarded from bases in the community instead of from distant institutions. Under the new Act, at least half of those persons living in large facilities in 1974 were to be returned to community living within a five year period.

Through the 1970's, new legislation continued to be passed which changed the basic features of the health care system. Significant among this legislation were The Denture Therapists Act and The Health Disciplines Act of 1974. These Acts set down new rules for the governing of the five major health professions and fields: dentistry, medicine, nursing, optometry and pharmacy.



A pleased Premier Leslie Frost at the Ontario Hospital Insurance Plan inaugural

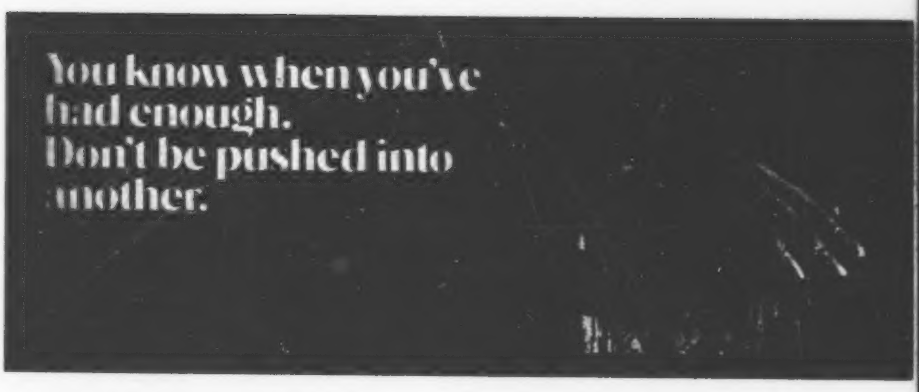
The Ministry also continued to initiate and expand its own projects throughout the 1970's. It opened 11 detoxification centres across the province to provide the initial step in the medical and social rehabilitation of chronic drunken offenders. At the same time, it began an alcohol education program, and guidelines for the establishment of non-smoking areas were prepared based on the 1975 Task Force Report on Smoking and Health.

The government Drug Benefit Plan was established in 1974, and extended to all senior citizens and welfare recipients in 1975.

The Funeral Services Act was passed, and included provisions for the licensing and setting of standards for such establishments.

Each time legislation was passed, it meant new tasks for the Health Ministry and often meant the establishment of a new branch or section to handle the added duty.

In 1976 a pilot project linked the Toronto Central Laboratory with the Timmins Public Health Laboratory by telecommunications. The use of telecommunications to provide faster and clearer information to various parts of the health care system would grow spectacularly over the next few years and in 1980 the first linking of separate hospitals by two-way television occurred.


You know when you've had enough.
Don't be pushed into another.

The air ambulance service was another technological breakthrough. It began in 1977 as a pilot project, with a "chopper" based at a small airport near Metro Toronto and named, in a public contest, Bandage 1. In 1981, Bandage 1 would be joined by two more helicopters and two fixed-wing airplanes which would be based across Northern Ontario to provide emergency transport for patients in the more remote areas of the province.

In 1977, money from the provincial lotteries was made available for health services. An initial $15 million was allocated for health research under the Provincial Lottery Health Research Awards Program. That year, the Ministry provided five CAT scanners for five health sciences centres. The scanners take over where x-rays leave off, providing cross-sectional pictures of virtually all of the body's internal organs, systems and bones. The following year, several other locations were selected for CAT scanners, and regulations for the control of the new diagnostic tool were set down.

In 1977 the Ministry provided funds for five CAT scanners for use in Ontario. There are now 24 scanners in the province.

The CAT scanner examines cross-sections of the body, including soft tissue, through the use of a narrow x-ray beam and computer print-outs.

During the 1979–1980 period, the Ontario Council of Health — the senior health advisory body — completed and published a comprehensive review of mental health services in Ontario. In a second report, the Council examined the experiences of jurisdictions with user charges for insured health services. These and similar reports formed the basis from which health care would evolve in the 1980's.

The French Language Service and the Metrication Office were expanded. New technologies were introduced, hospital facilities expanded and programs explained and improved.

The Ontario Hospital Services Commission had played an important role in the regionalization of hospital services and in community involvement in the planning process. It contributed to the rationalization of services through the development of Hospital Planning Councils, the predecessors of District Health Councils. The first formal District Health Council was established in the Ottawa-Carleton region in 1973. Additional councils were added to the system in 1980 and 1981, until more than 92 per cent of Ontario's population was served by them. To date, 25 District Health Councils take the pulse of their communities and advise the Ministry on ways to improve health services at the grassroots level.

In late 1981, the Ministry gave local communities even more direct control over their health care needs by removing the Ministry-set ceilings on charges for private and semi-private accommodation in general hospitals. This meant that such rates could be set by the hospitals themselves in accordance with local conditions, and that extra revenue could be used for improved patient care. At the same time, the hospitals were told they would be allowed to retain all their own revenues rather than be required to return excess revenues to the government.

The health care system has come full circle. Formed in the community in the beginning, it is now being returned to the community wherever this will most benefit the people of Ontario.

A modern hospital ward at Women's College Hospital in Toronto

One hundred years of health care; one hundred years of caring. Today the health care system faces not a young, pioneering challenge but a mature, and dynamic one. The major problems are no longer isolation and a population beset by the continual onslaught of infectious disease epidemics; they are rather the sheer immensity of the choices to be made in health care and a population that is aging teadily and shifting its demands and needs.

The renewed emphasis on the community coincides with a parallel event: a new Public Health Act — The Health Protection Act — to be enacted nearly 100 years from the inception of the last bill.

The tools of health are today awesome in their ability to examine, analyze and overcome disease; the services of the health care field are impressive in their variety, their scope and their availability. The access to health care in Ontario is universal thanks to government-run health insurance.

The character of the people who work to maintain and to build today's health care system has not changed in 100 years. They are still devoted to searching for the answers that could, someday, offer all of us greater freedom from the ills that disable both the body and the mind.

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